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CHARTING A COURSE FOR HEALTH CARE REFORM: MOVING TOWARD UNIVERSAL COVERAGE

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BEFORE THE

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UNITED STATES SENATE

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FIRST SESSION

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CHARTING A COURSE FOR HEALTH CARE REFORM: MOVING TOWARD UNIVERSAL COVERAGE

WEDNESDAY, MARCH 14, 2007

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Kerry, Lincoln, Wyden, Stabenow, Salazar, Grassley, Hatch, Thomas, Smith, and Crapo.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

In the wisdom of Ben Sirrah in the Catholic and Eastern Orthodox Bibles, it is written, "There are no riches above the riches of health." And a Swiss poet wrote, "Health is the first of all liberties."

America is the richest nation in the world but, to our shame, remains the only industrialized nation that does not think itself rich enough to guarantee its citizens health coverage. And America is the freest of all nations, but we remain the only major western nation that is not guaranteed the first of all liberties.

At the core of America's health care crisis is the debate over whether health care is a right or a privilege. At the core of our crisis is the question whether health care is just another commodity or a fundamental human need.

I believe that health care should be a right. I believe that America is rich enough, and good enough, to guarantee that right. I believe that we must begin to work toward that goal today.

America spends more than $2 trillion a year on health care, but we have 47 million uninsured and we have relatively poor health outcomes. America has many of the world's best doctors and hospitals that perform the most advanced life-saving procedures, that successfully treat the most serious illnesses, and that unfailingly expand the bounds of medical innovation. But this best-in-the-world medical system is out of reach for millions of Americans.

One in six Americans does not have access to health care except for an over-crowded emergency room. In my State of Montana, an even greater percentage of people have limited access to health care: that is, one in five Montanans lacks health insurance.

Businesses struggle to offer health benefits and remain competitive in the face of ever-increasing costs. Employees grapple with having to pay more for coverage, while getting less. For too long, Congress has remained idle as health care costs have spiraled out of control. For too long, Congress has done nothing as the ranks of the uninsured have grown. The people of my State of Montana, and of the Nation, deserve better.

Today we begin down a long and arduous road. Today we begin, again, the journey toward universal coverage. It is a road that we must travel. Everyone seems to agree that we need to do better, but discussions of how to proceed seem inevitably to end in stalemate. People seem, inevitably, to deadlock over who will make sacrifices and which ideologies must bend.

But standoffs must become a thing of the past. The American people deserve better. Why start down this road? The short answer is that we must. The problem has grown too large, and the situation too dire, for Congress not to act. We must engage in extensive and thoughtful dialogue and begin to get answers, and I suggest we begin today.

I have studied many proposals being put forth, and I am optimistic because I see the beginnings of a consensus. I see five broad principles of reform. I intend to hold a series of hearings to explore each principle at a later date, in greater depth. In having an open and honest dialogue, I am confident that we can build momentum.

The first principle is universal coverage, our subject today. Universal coverage is essential if we are to make meaningful progress on the other four principles. We cannot address the health care system and leave a growing portion of the country behind.

The second principle is sharing the burden. Neither the employer-based system nor the individual market can fulfill the demand for affordable, portable quality coverage. I believe the way to help ensure affordable coverage is to create better and greater pooling arrangements.

The third principle is controlling costs. America cannot sustain its current rate of growth in health care spending. Any serious proposal must reduce the rate of growth of health care costs; our economy depends on it.

The fourth principle is prevention. American health care tends to address what happens when you are sick. By making prevention the foundation of the health care system, we can spare a patient's needless suffering and can avoid the high cost of treating an illness that has been allowed to progress.

The fifth principle is shared responsibility. Who will bear the burden in this new system? The answer is, everybody must shoulder the burden together. Health care coverage is a shared responsibility and, therefore, all should contribute.

Today's hearing is the first step on the road to reform. We will hear from four individuals who are lifelong experts in health care. They will help us start our journey. Along the way, we will have more help from more experts as we convene subsequent hearings as we begin to drill down even more.

With their help and advice, let us set out on the road to health care reform for all Americans. Let us travel down the road that will keep America a rich nation, and a free nation. Let us also go down

the road that will take our citizens to the greatest of riches and the first of all liberties, that of health.

I would like to turn to Senator Grassley.

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Yes. Thank you, Mr. Chairman. You have described the situation very accurately, a situation that is untenable. However, I am heartened by the fact that we are seeing more new policy ideas as more people realize the seriousness of the situation. For example, the President has provided us an outline to consider in looking for ways to cover the uninsured. It is not perfect, but it is a place to get started.

In a big, politically sensitive issue like health care reform, but particularly as it relates to Medicare or Medicaid, it is highly politically sensitive. Whoever is President has to get out in front of it if there is any hope of Congress taking any action.

So the President gets it started by using the tax code to create incentives, along with the public/private partnership of the Affordable Choices initiative that he has put forward. Real solutions for the uninsured will involve proposals that use many tools, not just one size fits all.

I support ideas that incentivize greater private coverage. Covering everyone with government-run health care is not the right direction for America unless you want to do like a lot of countries do and have political decisions that are made about rationing health care as opposed to giving people access to health care through private decision-making.

I also think that Senator Wyden has made a very serious proposal with his Healthy Americans Act. It seems like he has written a bill that has something for almost everyone. If that is the case, he is close to having an answer.

But with all seriousness, I think Senator Wyden is very passionate about this subject. I think his tireless efforts to get people to pay attention and to contribute to the debate is opening the door, as a Senator can do—maybe not the same way that the President, with the bully pulpit of the presidency, can do—but we all have a problem here, and we all have to pitch in.

Mr. Chairman, moving major legislation during a presidential election cycle is very difficult, but not impossible. This committee has done it in the case of Welfare reform. That was 10 years ago. This committee has done it in regard to the Medicare drug benefit during a presidential cycle; you and I worked together to accomplish that.

So I think that we should not fall under the cloud that, just because this is a presidential cycle, that nothing can get done. I think the five meetings that you have scheduled in this area are an indication that you are very serious about it. And it does take the leadership of a Chairman of a committee to get this done, so I compliment you for that.

I am encouraged by the fact that it seems there are more people in Congress talking about the issue than at any time in the last decade. So, let me finalize my statements by saying that we have

enough on the table that we have an opportunity to move beyond talk and take substantive action.

The number of uninsured is rising. Many employers do not provide coverage. Those employers that do provide their employees coverage are finding it challenging to continue to provide health benefits for their employees while staying competitive.

With every day that passes, we only make fixing the system more difficult. We are running out of time to make changes that will put us on a path towards a more sustainable health care community, or at least the longer we wait the more difficult that is going to be.

Leadership must come from those on this committee. When it does, there will be change as there was in the case of modernizing Medicare, and in the case of modernizing Welfare. So, I thank you for your leadership.

I have a longer statement I want to put in the record.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. Thank you very much, Senator Grassley.

We now have our witnesses today. Let me just, first, thank all of the witnesses for coming. Some have come some distance. You all are very renowned in your fields, and you have given a lot of thought to this subject.

This first hearing is designed more as sort of a 50,000-feet kind of overview with the goal of trying to bring people together here, not to be divisive, but more toward consensus here; what are the goals, the problems, that we have so we can tend to agree what the problems are and the goals are and, later on in subsequent hearings, start to put some of the pieces together. At least try to do our very best.

The first witness is Dr. Jim Mongan. He is the president and chief executive officer of Partners HealthCare in Boston. Next is Stuart Altman, who is dean and professor of National Health Policy, The Heller School for Social Policy and Management at Brandeis. Mr. John Sheils is vice president of The Lewin Group. We have spent a lot of time looking at The Lewin Group's recommendations. Everybody on this committee knows The Lewin Group, I will tell you that. We also have Richard Frank, who is vice chair of Citizens' Health Care Working Group of Boston, MA.

So, Dr. Mongan, why don't you proceed?

STATEMENT OF JAMES J. MONGAN, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, PARTNERS HEALTHCARE, BOSTON, MA

Dr. MONGAN. Thank you, Mr. Chairman. I am Dr. Jim Mongan, president of Partners HealthCare, which is a health system founded by key Harvard teaching hospitals.

As I came here this morning, I remembered the first time I entered this room 37 years ago as a young physician, newly hired as a staffer for the Finance Committee, working for Senator Russell Long and Senator Wallace Bennett.

The CHAIRMAN. Did you work for them together?

Dr. MONGAN. I worked for both of them.

The CHAIRMAN. Both Democrat and Republican together?

Dr. MONGAN. Indeed, we did.

The CHAIRMAN. Well, we are trying to follow that model right here.

Dr. MONGAN. Yes, sir. I stayed for 7 years, and I developed tremendous respect for this committee.

These health financing issues were difficult then, as they are now. In fact, over time the situation has only gotten worse. At our best point in 1976, we had 23 million uninsured, or 11 percent of our population; today, these numbers are 47 million and 16 percent. So, it is long past time to act. I applaud the committee for holding these hearings.

I want to address three questions this morning. First, why is health insurance important? Well, it is important for reasons involving health, economics, and simple justice.

Although some believe that the uninsured get care when they really need it, the definitive Institute of Medicine Report on the Uninsured in 2004 by a committee I was privileged to serve on demonstrated that the uninsured receive fewer services and are much more likely to be hospitalized for avoidable complications of illness. The report found that they had a 25 percent higher age-specific mortality. So, health insurance is about health, not just about dollars.

But it is also about economics. The same IOM report estimated that the annualized economic cost of the diminished health and shorter lifespans of Americans who lack insurance is between $65 and $130 billion.

Finally, expanding health insurance coverage is a matter of basic social justice. Most families will never be free of fear of financial ruin without health insurance coverage.

Second, why has legislating on this issue been so difficult? Well, for two reasons. First, expanding health insurance comes with the need for additional revenues. The same 2004 IOM report estimated at that time that the cost of legislation would be from $70 to $100 billion a year.

Now, in terms of our $2 trillion of health spending, these numbers are not insurmountable. In terms of Federal taxes, this revenue could be raised and still leave taxes at or below levels of the 1990s, which underpinned one of our most productive economic eras. Yet, raising revenue is always difficult.

The second reason that legislating is difficult is we are divided as a Nation ideologically between those who favor a government approach and those who favor a market approach to health issues. We have been stuck for 25 years on this point.

So now the last question: are there paths towards success? My experience in Massachusetts this past year makes me think there are, not because I think the Massachusetts plan is perfect, nor because I think States can ultimately deal with this issue on their own.

Rather, in Massachusetts I saw a successful approach to the two difficulties which I just described. With respect to revenue, leaders in Massachusetts addressed the revenue issue from the perspective of shared responsibility: everybody pays something.

Federal funds, new State funds, preexistent insurer and provider taxes, new employer contributions, and mandated payments by in-

dividuals were all utilized. Is the resulting package a perfect balance? Probably not. But we have made a good start, and the legislature can improve upon it in the future.

With regard to the ideological stalemate between markets and government, Massachusetts leaders demonstrated admirable intellectual humility. None of us has all the answers, so the legislature crafted a package with regulatory and market approaches, including the best thoughts from all sides.

So the path to success consisted of an honest appraisal of the problem, a shared commitment to solutions, a philosophy of sharing and fairness regarding revenue, and a sense of intellectual humility. I commend this formula to you as you begin your important work on universal coverage.

Thank you very much for the opportunity to appear.

The CHAIRMAN. Thank you, Dr. Mongan.

[The prepared statement of Dr. Mongan appears in the appendix.]

The CHAIRMAN. Dr. Altman?

STATEMENT OF STUART H. ALTMAN, Ph.D., DEAN, AND SOL C. CHAIKIN PROFESSOR OF NATIONAL HEALTH POLICY, THE HELLER SCHOOL FOR SOCIAL POLICY AND MANAGEMENT, BRANDEIS UNIVERSITY, WALTHAM, MA

Dr. ALTMAN. Well, thank you, Mr. Chairman. It is not often that I get to say that I have not been involved as long as Dr. Mongan. It was only 36 years ago that I had the privilege of working before this committee when my boss at that point, the Secretary of HEW, Elliot Richardson, testified on the need for national health insurance. I feel as strongly today as I did then 36 years ago.

Unfortunately, in these 36 years I have come to be a little pessimistic, and people have coined the term "Altman's Law" that I would love to see repealed. It basically says that almost every American and advocacy group supports some form of universal health insurance, but if it is not their preferred version, their second-best alternative is to maintain the status quo.

I am sure you know that well, as different groups come up before you. I really want to commend you and the committee for working on this, and I hope that "Altman's Law" gets repealed in this session of Congress.

Let me just make two overriding points about health insurance. I strongly support what Jim Mongan said. Much as I believe that there are some very interesting proposals being put forth, and some of them require fairly radical changes, I have come to believe that we should, wherever possible, improve on our existing health insurance system with its various pieces—an employer base, Medicare and Medicaid—because to do otherwise creates such opposition that ultimately we fail. It is not that I do not believe that a lot of other plans may even have more merit, but they ultimately fail because of the opposition of those who stand to lose.

The second point, I have been a strong believer in the need to control our health care spending. I worked for 15 years as Chairman of the Prospective Payment Assessment Commission to help keep Medicare spending within defined limits. But I believe to try

to do both at the same time generates such opposition that we wind up doing neither.

There is one area that I do want to mention right off the bat. When I worked for Senator Kerry in his bid for the presidency, we developed a reinsurance system. The main reason for having what I call a high-cost reinsurance system is to get premiums for our existing employer-based system down.

And there is no better way to do that, I believe, than to take the really high-cost cases, those between $50,000 or $100,000, and share them among all of us and have the government pay for it, either at the State level—and I am advocating it in Massachusetts—or at the Federal level. If we do that, we can lower premiums 10, 15, maybe even 20 percent in some cases, and it will allow us to build on our current system.

Now, I know you want to focus on the big issues. As Jim pointed out, the uninsured bear a tremendous burden by not having health insurance protection. But the burden of the uninsured goes beyond them. We have created in this country a hidden tax that is used to support the billions of dollars of care that is received by the uninsured. This tax is paid by all of us, and it disproportionately falls on those who have the best coverage. The uninsured do get care, but they get it in the most expensive way. Dr. Mongan can give you chapter and verse of what happens in his institutions when a very sick person comes into the hospital needing care. His institutions, like most, try to push the expense onto others where they possibly can, and in the end it winds up on our health insurance bills.

If you are a big employer like General Motors or what used to be U.S. Steel, they are the ones that bear the biggest burden. They bear the burden for their own employees, for the families of employees, for retirees, and for the uninsured. We need to help them, and I think we need to do that soon.

Second, institutions like the ones that Dr. Mongan runs and the one whose board I happen to be on, the Tufts New England Medical Center, bear the burden as well. Not all the costs of care for the uninsured can be passed on to others. Hospitals must eat some of the expenses of this care.

As a result, hospitals often do not have the funds to improve the quality of patient care. This is a particularly serious problem for safety net hospitals, which have difficulty obtaining sufficient funds. So that is a second area that needs to be looked at in terms of the burden generated by 48 million uninsured Americans.

Then, finally, all of us who are insured bear a burden. Because we have such a patchwork health system, some individuals get locked in to a job they don't like because of fear that the job they might get does not have health insurance, or they happen to be in one area and they would like to be in another area and they are afraid to move.

What it does is, it reduces the productivity of our economy because it makes our system less flexible. So we cannot just focus, much as it is important, on the uninsured. Failure to act has a negative impact on our whole system. So, I applaud what you are doing, and in any way I can be helpful, I would love to do that. Thank you so much.

The CHAIRMAN. Thank you, Dr. Altman.

[The prepared statement of Dr. Altman appears in the appendix.]

The CHAIRMAN. Mr. Sheils?

STATEMENT OF JOHN SHEILS, M.S., VICE PRESIDENT, THE LEWIN GROUP, FALLS CHURCH, VA

Mr. SHEILS. Good morning. My name is John Sheils. I am a vice president with The Lewin Group. We are committed to nonpartisan analyses of health policy. We do not advocate for or against any legislation.

Right now, the uninsured population is growing at a rate of about 1 million people per year, 1 million since 1990. That suggests we will hit 50 million uninsured by the end of this decade.

Costs, of course, are very high in the United States. They average about $6,500 per person, which is roughly twice what is spent in Canada and some of the other European Union nations. Costs are growing at about 2 or 3 times the Consumer Price Index, which is basic inflation. Interestingly, you are seeing similar rates of growth in other countries.

Wage growth is compromised by this growth in cost. Quite simply, after the employer pays for increased costs for benefits, there is less to pass on in the form of higher wages. It also has affected our ability to compete internationally.

Due to the increasing costs, we have seen, of course, an increase in the uninsured, but we also, interestingly, have 6 million people out there, uninsured, who are offered coverage through work but have declined it, presumably due to cost; 4 million workers and 2 million dependents.

The problem of the uninsured, of course, creates avoidable health care costs. The Institute of Medicine estimates that up to 18,000 people die per year because they are uninsured; of course, worker productivity, we believe, is compromised.

But there is also a cost shift associated with it. When somebody goes into the hospital and they do not have insurance, the hospital cares for them. They incur these costs, but they do not get paid for it. So they have to increase what they charge other payors, private payors, for the coverage. So there is a substantial cost shift we see associated with having uninsured people, and we are winding up paying for it anyway.

Medicaid is another important contributor to the cost shift. Payment under Medicaid for physicians can be half of what it is under Medicare, which can be 20 percent less than private insurance. Medicaid payments to hospitals are generally less than the cost of providing the care.

This presents another shortfall in reimbursement for the providers, which again is passed on to privately insured people in the form of the cost shift. In fact, at this point we believe that the cost shift due to the Medicaid payment shortfalls is actually greater than the cost shift associated with the uninsured.

This creates an insidious cycle that generates new uninsurance. You get premiums going up for employers, you see people drop coverage, you get an increase in the uninsured which increases uncompensated care, maybe they go into Medicaid, it generates undercompensated care, which again pushes up private premiums. You have this cycle that generates an increase in the uninsured.

There is another form of cost shifting I wanted to touch on. When an employer offers health insurance, they typically cover the spouse and the children under a family policy. Many of those spouses, almost 20 million of them, are actually working somewhere else, but their employer apparently is not providing coverage.

So you have a situation where you see the cost of covering workers being shifted from low-coverage industries like services and retail towards high-coverage industries like manufacturing, which is precisely the group that is having the most trouble competing in international markets.

People are fond of saying we do not have rationing of health care in the United States. Of course, that is wrong. We ration health care in this country by limiting what the uninsured and low-income people can get in the way of care. Eighteen thousand people lose their lives because of uninsurance. Many of those covered under Medicaid cannot find a physician to serve them.

There is a much-publicized story about what happened in Prince George's County, I believe last week, where a child died because of an abscessed tooth infection that infected the brain. The problem was, they were not able to find a dentist who was willing to treat the child. So, it is not first-rung health care, although some States have worked very hard to make it such.

The key to the kingdom is your private insurance card. If you have a private insurance card and it is medically necessary, you will probably find that it is covered. However, if you are uninsured or in Medicaid, as I have explained, it is pretty much hit-and-miss.

We need to end this insidious cycle of cost shifting, inequitable payments for care, and the rising number of uninsured people. Underpayments in health care, uncompensated care, and inequity in how we pay for care will contribute to continuing uninsurance.

For any program to be successful, we are going to have to eliminate the relationship between cost shifting and increases in the uninsured population.

Thank you.

The CHAIRMAN. Thank you, sir. Thank you very much, Mr. Sheils.

[The prepared statement of Mr. Sheils appears in the appendix.]

The CHAIRMAN. Dr. Frank, you are our clean-up batter here.

STATEMENT OF RICHARD G. FRANK, Ph.D., VICE CHAIR, CITIZENS' HEALTH CARE WORKING GROUP, BOSTON, MA

Dr. FRANK. Thank you for the opportunity to share with you the experiences of the Citizens' Health Care Working Group.

As you know, the working group was created by legislation that was sponsored by Senators Hatch and Wyden, and was created to engage the public in a nationwide discussion about how to improve health care in America.

The 14 citizen members of the working group represented an informed cross-section of the American people. Over about 18 months, the working group engaged in fact finding and dialogue about the health care system with experts, stakeholders, and ordinary citizens.

We reviewed more than 100 public opinion polls on health care, traveled to 30 States, and more than 7,000 people attended a total of 98 meetings that we initiated. In addition, we had another 20,000-plus responses to our online surveys where people shared their views and their suggestions with us.

We heard, actually, a remarkable consensus across the Nation. We heard a call for a health care system that is fair, affordable, and available to all Americans. A clear majority of participants in community meetings and those who responded to national polls that were conducted over the last few years are in favor of universal coverage.

However, as we discovered, universal coverage means a lot of different things to a lot of different people, and several approaches need to be analyzed, vetted, and debated.

It is this sentiment that led to our first recommendation, to establish a public policy that all Americans have affordable health care. That would serve as a marker for the ultimate goal.

The overwhelming majority of Americans that we heard from believe that fixing the system has to start now. That is why the working group recommends some immediate steps, along with some later actions, that target 2012 for a set of core benefits for all Americans.

Our second recommendation calls for immediate action to guarantee financial protection against very high health care costs. It proposes creating a program that would ensure some level of protection for everyone. This program could be structured in a number of ways using either market-based or a sort of social insurance-type model. This step has the additional virtue of rapidly establishing the principle of universal coverage.

Our third recommendation also calls for immediate action, which is to foster innovative, integrative community health networks. The goal of this recommendation is to help communities develop systems of local health care providers to ensure that more people can access an array of medical care that will meet their basic health care needs.

A particular priority is making an array of effective and efficient services available to low-income and uninsured people immediately. Perhaps the most challenging component of the working group strategy is our fourth recommendation, which defines a core set of benefits for all Americans.

We recognize the difficulties of doing this in the context of important financial constraints. This was particularly evident when we brought the issues up to the American people in our meetings. A private/public entity, insulated from the usual pressures, should be charged with applying the best science and economic thinking aimed at that purpose.

Our fifth recommendation is to continue to promote efforts to improve quality of care and efficiency. Everyday Americans sensibly believe that we can do a better job with the $2 trillion that is spent every year on health care.

There are a variety of efforts under way by the government, by philanthropies, and by the private sector aimed at improving efficiency and quality. We were particularly impressed by results from

some integrated health care systems across the country that have shown the ability to improve care and cut waste.

Our final recommendation focuses on the end of life. End of life care needs to be fundamentally rethought. Americans are distressed seeing loved ones approach their end in pain, cared for in places they do not want to be, and at great cost. It is emblematic of many of the problems of our health care system, generally.

We were presented with a variety of innovative models that point to ways to make big improvements in how Americans are treated at the end of their days. Of course, the suggestion for addressing these types of shortcomings in today's health care system can be done without considering how to pay for improvements. There is a strong sense in the American public that reallocation of existing funds and increased efficiency should be the first step.

However, our data analysis also shows that the majority of the population is willing to pay some more, if that is what it takes to cover all Americans. Based on our review of studies by CBO, the President's Commission on Taxation, and independent research, we believe that restructuring public subsidies would provide for a significant set of funds to target and support reform.

Absent meaningful policy action, we expect the number of uninsured to grow, financial pressure on public budgets and safety net providers to intensify, and there are health consequences from these, as you have heard, in the form of shorter lives and heavier burdens of disease for the growing number of uninsured people.

This can, and must, be avoided. Doing nothing about health care will certainly cost us more tomorrow than it would by acting today.

Thank you. I am happy to take any questions you might have.

The CHAIRMAN. Thank you, Dr. Frank.

[The prepared statement of Dr. Frank appears in the appendix.]

The CHAIRMAN. Mr. Sheils, I have a question for you. You mentioned a cost shift, Medicaid and uninsured to private pay. Does Lewin have any analysis of just what percentage of private pay is attributable to costs shifted to them, total Medicaid and uninsured? Roughly what percent?

Mr. SHEILS. We have heard up to 10 percent. Ours tends to come closer to 5 percent from our analyses.

The CHAIRMAN. So between 5 and 10, say.

Mr. SHEILS. Yes.

The CHAIRMAN. Now, assuming that those folks were all private pay, the Medicaid and the uninsured, then would the net cost be about the same or would the net cost be better? I am hoping that your answer is that the net cost would not be as great because there are inefficiencies currently with the cost shift transfer. But would the net be the same, or do you know?

Mr. SHEILS. Well, the first step would be increasing the payment rates, perhaps, to something closer to private levels. That would reduce the cost shift, which would, to some degree, reduce the prices for private health insurance.

Raising our reimbursement rates for Medicaid would not, in itself, result in a 5- to 10-percent reduction in private insurance. You need to couple it with, if it is an insurance-based system, a program that intensifies competition.

It is interesting, though. There are some beautiful charts which show, historically, that when public program payments improve, private sector costs grow more slowly. Then when public sector payments decline, the private insurance grows proportionately. So it is symmetrical.

We know that if you did improve payment rates, there would be at least some reduction. But I think to get the full reduction or anything close to the full reduction, we have to intensify competition in the insurance industry.

The CHAIRMAN. This leads to another sort of basic question that a lot of people ask, a lot of us who grapple with all of this, some way to get rid of the ideology and to get people starting to think about solutions rather than ideology, private pay versus government and so forth.

Which sort of begs another question, which is, do we try to build on and improve the current system—Dr. Altman, I think you basically say yes—or do we try to come up with something that could be innovative and quite new, something that America has not experienced? Some talk about single pay. Some look at other countries, and so forth, who deal with both costs and coverage.

But I would just like your thoughts on kind of how we start getting various groups working better together, putting ideology aside. Dr. Mongan, you talked about your Massachusetts experience, that people in Massachusetts tended to exercise a little bit of humility in trying to get things together. But I will just go down the line here.

Maybe Dr. Mongan, first, your thoughts on how to get people together. And then there is a second question, which is, do we tend to work with what we have, increased Medicaid, CHIP, Medicare and some private, or do we go to something that is pretty new and different?

Dr. MONGAN. So I guess I would venture a few observations before turning it over to my colleagues. As I indicated, I think a big part of the way to get people together is to try to come to some shared understanding of the dimensions of the problem and some kind of commitment to the fact that everybody is going to have to give a little and get a little.

That sounds corny, like "Mr. Smith Goes to Washington," but I think that is, in fact, what happened in Massachusetts at some point in the process. I would say, as a general rule, it is easier to achieve that kind of consensus if you are working with known elements of the existing system.

I am not saying that is necessarily the best answer, but I would say to get us over this hump and to get the uncovered covered, I think probably most of us who have been in these battles for 30 years or so would say your chances of doing that are better by working with the various pieces of the current system. You may find out a decade later you have to make more dramatic change than that, but I think that would be what my experience is.

The CHAIRMAN. I appreciate that. We are trying to repeal Dr. Altman's law here. So Dr. Altman, why don't you respond?

Dr. ALTMAN. Well, obviously, $2.2 trillion develops a lot of very strong advocates for their piece of the pie. I have developed some pretty radical ideas in my lifetime—I do not want to put them

down, because some of them are quite interesting—but I share Jim's concerns. As I said, I have watched some very good ideas go down in flames because of the power of the forces that are there. I believe, at the end of the day, what we do is we hold hostage the poor and the uninsured to some very interesting new ideas, and it is about time they had a shot to be under the tent.

I would support Jim. If, down the road, after we have everybody covered and we are trying to control costs, we find a better way to do it, let us do it. But to do it in the beginning almost sets us up for failure, I am sorry to say.

The CHAIRMAN. Mr. Sheils?

Mr. SHEILS. Well, I guess I would point out——

The CHAIRMAN. You can have a different view. That is all right.

Mr. SHEILS. I am sorry?

The CHAIRMAN. It is all right to have a different view here. [Laughter.]

Mr. SHEILS. During President Clinton's effort to reform health care, they had a plan that would have been a major restructuring of the health care system, but at the time the employers were investing a lot in managed care, and they believed that they were going to get things under control themselves. Their argument was, well, leave us alone and we will just do it. It worked. We had health care costs growing much more slowly than ever before.

But now we are not finding as many ideas with the employers. Some employers appear to be out of ideas entirely. Some are doing very innovative things, but there are not many of those ideas floating right now. I think that where it might not have been a good idea to do a dramatic reform, say, 12 years ago, I think now we may be there. Many employers are telling us, they just want to get out of the business of providing health care.

The CHAIRMAN. Thank you. My time has expired. We will have to get back to you, Dr. Frank, in the next round.

Senator Grassley?

Senator GRASSLEY. Yes. Thank you very much. I appreciate the testimony.

My first question is directed to any or all who want to answer it; it is to the panel, generally. It is in regard to the children and the SCHIP debate that is coming up here shortly.

These children are uninsured either because the employer does not offer health care coverage or the costs are prohibitive. Congress is going to be reauthorizing the program.

A number of proposals that we have before us would expand this public coverage to higher-income children and adults. Some have raised concerns about the quality of care that children receive through Medicare and SCHIP because of several factors, including things you have brought up in the panel discussion about very low provider reimbursement rates.

The President has offered his ideas about reforming the tax code treatment of health care to help more people get covered. Senator Wyden—I have already referred to his as a thoughtful proposal.

So my question is, should we be looking in this committee just at SCHIP reauthorization in a vacuum or should we think about the issue outside of just the SCHIP box?

For example, should we take a more comprehensive view and consider SCHIP expansions alongside efforts to make the tax code more equitable or to help more uninsured people obtain health insurance coverage?

Dr. MONGAN. Well, Senator, my own view would be that, clearly, covering kids is very, very important, and appropriate extensions of the SCHIP program are critically important.

I would love to see that done as part of a broader package that deals with not only uninsured kids, but also uninsured adults. But I must say, if the committee finds itself unable to agree on a broader package, then I would clearly want to make sure that the SCHIP piece went forward. So I think my ultimate answer would depend on what position you find yourselves in in terms of being able to do a more comprehensive package.

Dr. ALTMAN. Well, I might as well be consistent if I am not right. That is, I do believe you should reauthorize SCHIP and, if possible, make some expansions in it. Then if we can move forward on a basic reform, I think it will reduce the cost of SCHIP because many of the SCHIP children will get covered, either through the employer-based system or some other program.

So my strong recommendation would be that SCHIP is really a model. It was bipartisan in its preparation, it builds on the existing system, and it gives States flexibility. I really want to emphasize the value of State involvement in this. I think the States are playing a very critical role, and SCHIP is a very good example of it, so I would support it.

Mr. SHEILS. I would just advise, do not let the perfect be the enemy of the good. I have heard Senator Kennedy say that several times. Do not let the hope of universal coverage get in the way of doing something to cover the kids. I guess I would advise that most strongly. Thank you.

Senator GRASSLEY. All right.

There are two things about——

The CHAIRMAN. You forgot Dr. Frank, now.

Senator GRASSLEY. All right.

The CHAIRMAN. He is feeling left out.

Senator GRASSLEY. Well, you do not have to feel left out. I will be glad to hear your view, too.

Dr. FRANK. Thank you. I agree with the strategic points made by my three colleagues here, but I do want to emphasize that doing something about the delivery system is important.

I think starting to use the government's power, to use the government's clout in the marketplace to start to move the delivery system, and one that produces higher quality and greater efficiency, is something you ought to work on, but I do not think it should come at the cost of not acting on SCHIP.

Senator GRASSLEY. You know about the tax code in regards to fairness, that people who have health care coverage get the benefit through the employer—the tax deductibility—and the self-employed get it as well. Then people who do not have it, who are not fortunate enough to have it through their employer, you have a great deal of discrimination against them through the tax code.

And I realize that making a change in the tax code alone is not enough. But do you think that we should fix the fundamental in-

equity in the tax code that discriminates against the working poor from this standpoint? Mr. Sheils and Dr. Frank?

Mr. SHEILS. Actually, I am going to let someone else speak. I forgot the question.

Dr. FRANK. I will take a crack at that.

Mr. SHEILS. Oh, the tax code.

Dr. FRANK. I am sorry. Go ahead.

Mr. SHEILS. No, go ahead.

Dr. FRANK. The problem with the tax code, of course, is we lack this equity. If you have an employer plan, your benefits are tax-exempt. You do not have to pay taxes on them. If you do not have employer coverage, you have to buy your coverage in after-tax dollars.

One approach, though, is to eliminate the tax benefits entirely associated with employer coverage, or private coverage at all, and to just eliminate the tax incentives for purchasing health care instead of expanding it.

You do not have to do it in a way where you actually increase taxes. You could introduce some sort of a deduction or adjust the tax code in some way so that we are not increasing any taxes on people, but we are making the tax code neutral with respect to the purchase of health care.

Mr. SHEILS. I think certainly there is important work to be done to make it both more fair and more efficient. I think there is an important set of inefficiencies in the existing treatment of employer-based health insurance.

Our working group, and I personally, do not believe that getting rid of the deductibility would be appropriate. I think there are some virtues to the employer-based system. And staying with the notion of incrementalism that we were talking about before, I think it would be an error to sort of scrap it. But changing it, perhaps capping it, would be something that I think would make things fairer and more efficient.

The CHAIRMAN. All right. Thank you very much, Senator.

Senator Bingaman, you are next.

Senator BINGAMAN. Thank you very much. Thank you all for being here.

Dr. Altman, you have made the point that we have two big tasks: one is expanding coverage to everybody, the other is controlling costs, and we should not try to do them both because it is too hard. I understood you are basically saying, let us get everybody covered and then deal with the cost issue.

I certainly agree that if we are going to try to legislate universal coverage or some combination of things that gets us toward universal coverage, we should not include in that, provisions that try to solve the cost problem as well.

But the way I think about it, we ought to be trying to confront the two issues on a parallel track. I do not see just putting off consideration about the cost growth in health care until we get everybody covered. In the first place, most of us are not going to still be here by the time everybody gets covered, the way things have been going.

It seems to me that there are different initiatives that are going to have to be undertaken to begin to control costs. Could you elabo-

rate a little on what you think those are? What do you think the essential elements are of beginning to control costs?

I know Mr. Sheils talked about how he thought we needed to have greater competition, as I understood it. I think the phrase you used was "in order to get the full reduction in health care premiums we would need increased competition in the insurance industry." In your view, is that a part of the solution or is that going the wrong way?

Dr. ALTMAN. Well, first of all, let me support where you are coming out. I made my statement quite strong as much for effect. I think there are a number of things that we can do that will have an effect on costs. I particularly like what Senator Wyden has done with respect to preventive care and the need to improve such care. I think that is all positive. I think it adds to the system.

But I do not think it would fundamentally change the cost curves. Unfortunately, really making an impact—I mean, really, as opposed to marginally—would require substantial changes in the reimbursement system, would require changes in the availability of capital, would require the delivery systems to change, and would require us as patients to change our expectation of what we want for care.

This would not be marginal, and it will be attacked. I happen to believe, at the end of the day, it is necessary. That is the real message. If you want to have a substantial impact on cost, it will require more than just marginal changes. It is that, I fear, if we do that in conjunction with trying to put coverage into effect, that will ultimately run into a buzz saw.

But I do believe we need to move forward. I did not have time to say so, but I really support the need to do a number of things, particularly many of the things that are in Senator Wyden's bill.

Senator BINGAMAN. All right.

Dr. Frank, the fourth recommendation that you referred to is that we establish a national core of benefits and services, we set up a group to do that. I gather the administration's response came back and they do not favor that. They favor something that they call "Every American Should Have Access to a Basic Affordable Private Health Insurance Plan."

I am not clear what the difference is. I mean, why is it important to establish this? I mean, how does it help either control costs or expand access to actually establish what these core benefits and services ought to be?

Second, is there a disagreement here between you and the administration on this issue?

Dr. FRANK. I have, as yet, not seen the response from the administration. When I left Boston last night it had not arrived on my e-mail.

Senator BINGAMAN. But it came out while you were on the plane.

Dr. FRANK. Yes. I do not think it is necessarily a conflict. Since I have not seen it—it is consistent to use the private sector going to purchase that basic set of benefits. I think there are a couple of reasons.

One is, you need to define what insurance means. It is too easy to say everybody gets coverage and then that not have a lot of substance to it. I think the other thing is that, if you are going to rely

on private markets, then you have this issue of potential adverse selection and competition to avoid risks through the design of a benefit. And so establishing what at least a floor is, I think, would be useful for that reason.

Senator BINGAMAN. Any of the others have a comment on that, on the value of having a core set of benefits defined?

Dr. MONGAN. Senator, I have become somewhat skeptical over the years about the core benefit concept. In the years I was working here, I would say every Senator on both sides of the aisle, at one point or another, asked me to look at this issue. Everybody should not have a Cadillac; go design a Chevy or a Hyundai, or something of that sort.

It gets very hard to do because the things that people can easily agree on, you know, no cosmetic surgery, no private room, maybe no heart transplant, and you are at 0.2 percent of health care costs, because most everybody wants to include hospitals, doctors, drugs, et cetera.

Consequently, it is very difficult, I think, to agree on some core package that is really significantly cheaper than the other packages people might be looking at. So, I am not against trying to do some work, maybe not having quite as many mandates for special services as we currently do, but I would not put a lot of stock in being able to solve a lot of problems by coming up with some magic core benefit description.

The CHAIRMAN. All right. Thank you very much, Senator.

Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman.

Dr. Mongan, I appreciate what the States have tried to do, Massachusetts and California, just to mention a few States. But according to what I have been able to understand, the Massachusetts plan will only cost the State about $132 million more—maybe a little more than that, but not much more than that—in tax money per year.

Now, for the same plan, extrapolated to the California system, it is indicated it would cost somewhere between 7 and 9 billion new dollars.

So my question is, what do you believe the Federal role should be in helping these States, or any States that want to come up with innovative plans that may work?

Dr. MONGAN. Well, first off, Senator, as I indicated, I do not believe, in the long run, that this issue can be dealt with State by State across the country. Having said that, I am a big believer in encouraging the States to do what they can while we are working our way towards a national——

Senator HATCH. Well, we have such a big role in the Federal Government in so many different ways, you know: Medicaid, Medicare, CHIP, you name it.

Dr. MONGAN. Absolutely. Already. And I believe Senator Bingaman has a bill that is aimed at kind of supporting States with some planning funds to help towards their coming up with programs.

Senator HATCH. Right.

Dr. MONGAN. I would say that in Massachusetts the cost of the bill is substantially higher than that $130 million of State general

revenue. There is, as I say, money from all sources. A large amount of Federal money is in that pot.

Senator HATCH. Well, that is right.

Dr. MONGAN. The Federal Government has already helped in a significant way.

Senator HATCH. Well, let me just say, I want to thank Dr. Frank and others on the working group for the hard work that they did all over the country. It was really interesting.

Dorothy Bazos is here from New Hampshire. Would you stand, Dorothy, so everybody knows? She was on the working group. We are so happy to have you here.

Let me just ask another question to everybody on the panel. I think it is an important question. That is, what do you think about the HHS/administration approaches, which basically mean a budget-neutral manner, standard tax deduction for health insurance of $15,000 for a family, $7,500 for an individual, so that the deduction would be available to anybody who purchases insurance coverage in the employment sector or in the non-group market.

Then, of course, they are emphasizing health savings accounts. There are already 3 million people who have health savings accounts and are finding them efficacious and who want to save for their health care.

Some here have argued for association health plans that should bring costs under control to a degree. And, of course, keeping medical costs competitive by improving health care price and quality transparency is also part of the administration approach,

Part D, the 39 million Medicare beneficiaries who now have access to prescription drug coverage through Medicare Part D, which this committee had a big role in doing.

Of course, they would like to resolve the problem of medical liability reform. As a former medical liability defense lawyer, I have to admit, I think there is an awful lot of unnecessary defensive medicine that comes because of the threat of medical liability suits.

Dr. Altman?

Dr. ALTMAN. Senator, yes. First of all, I really was very pleased to see the President and the administration get out front on this issue. Second, I do believe a number of the options that they are pushing can have some positive effect.

I am concerned, however, about the President's plan for several reasons. First, the so-called "Cadillac"—or I am not sure in the current market Cadillacs would be the most expensive car out there—plans——

Senator HATCH. Sure.

Dr. ALTMAN [continuing]. Often include dental care and eye care, and stuff like that, which is what kicks them into the $15,000 as opposed to the $12,000 premium. Their basic benefits for health care are quite similar to a lot of others, except for one area: some of them have little or no deductible or copayment.

I happen to believe that coinsurance is an appropriate part of insurance coverage for everyone but the very poor. I do believe individuals should have a financial stake in making decisions on what care they receive. So, to the extent that we put a cap on high-premium plans for tax deductibility, I would not be against it, provided it was totally aimed at health care as opposed to——

Senator HATCH. Well, if you added for the poor, in the President's plan, a refundable tax credit, that might help bolster it.

Dr. ALTMAN. I thought that was great. I did. So there were positives. The other negative—very important. I do think that the way it was designed, it would seriously erode the employer-based system and the value of the pooling that goes on in the employer system.

Senator HATCH. That is happening anyway, is it not?

Dr. ALTMAN. Well, I do not think it is ending. It has gone from——

Senator HATCH. It is not ending, but it is surely happening.

Dr. ALTMAN. Well, it has gone from about 65 percent to 59. I am a big believer in pooling in every way. I think the Chairman talked about it. I think going towards the individual insurance market has some down sides to it.

Unless we really, really subsidize it big-time, it could lead to the number of uninsured growing substantially. So, in general I support a lot of what is in the President's plan, but my own view is that it is not the best way to go.

The CHAIRMAN. Thank you very much, Dr. Altman, and Senator.

Senator Wyden?

Senator WYDEN. Thank you very much, Mr. Chairman. I want to commend you for all of your leadership, Mr. Chairman, and also—he is not here—but thank Senator Grassley for his kind words about my Healthy Americans Act. I truly believe that, under the team of Baucus and Grassley, we are going to fix health care after 60 years.

I can tell you already, just in the last few months, Senator Conrad, Senator Lott, Senator Crapo, Senator Salazar, Senator Cantwell, and I have been working. We have been able to find a bit of common ground, and we are going to work with you, Mr. Chairman and Senator Grassley, and get this job done.

The first question I wanted to ask is for you, Mr. Sheils. Dr. Mongan says that to get to universal coverage you are going to have to raise taxes. Respectfully, Dr. Mongan, I would disagree very strongly with that.

We are going to spend $2.3 trillion this year. We have 300 million Americans. You divide 300 million into $2.3 trillion and you could go out and hire a doctor to handle every seven patients in the country and give everybody good, quality care. So I think the money is there, we are just not spending it in the right places.

My question to you, Mr. Sheils, is, is it not possible to get everybody covered for the $2.3 trillion that is spent today?

Mr. SHEILS. Absolutely. We spend, what is it, $6,500 per person in the United States, which is twice what is spent in other countries. The uninsured are predominantly younger people who are not very expensive to cover in the first place, so I would say we should be able to get by with $2.3 trillion.

Senator, you have introduced a bill. Again, we are not advocates, but you introduced a bill that we took a close look at that would achieve universal coverage without actually increasing what we spend as a Nation on health care.

It is not going to be easy. We have to take some steps to do it in your proposal. We have to take steps to form aggressive price

competition among insurers, I think. We have to eliminate the tax exclusion.

Basically the idea with this is that you cannot reduce your taxes by increasing what you spend on health care. If we can eliminate that feature, we will create an incentive to provide coverage. I think just about any economist anywhere will tell you that that is, at least to some degree, true.

So I believe it is quite possible to do it, but we will have to take some innovative steps. Innovative steps in streamlining administration, too, I think, will be very important and part of the formula for making it all happen. But there are other approaches that could be devised different from Senator Wyden's bill that would do the trick.

Senator WYDEN. Thank you very much, and for all of your analysis as well.

Dr. Altman, I am a great admirer of yours as well. My question for you is, how important do you believe fixing the broken marketplace is? Right now, the private insurance companies—certainly many of them—cherry pick and they take healthy people and send sick people over to government programs more fragile than they are. I have been for fundamental insurance reforms so you cannot do that; a number of others have been as well.

How important do you think stopping that cherry picking and creating a private market where people compete on the basis of price and benefit and quality is?

Dr. ALTMAN. Well, to the extent that it exists—and I do believe it exists—I think it should be stopped. The Congress has been trying to do that over the years. Now we require that a person who develops a serious medical condition continue to be insured, even if they change jobs, to make it more and more difficult to discriminate. I think there are more and more ways to do that, and you should do it.

I also believe in pooling, as the Chairman talked about. I think that we should be creating the marketplaces that you talk about. I think there are a number of ways to do it, but I do not believe we need to, or should, destroy the private insurance market or the employer-based system. I think we can get pretty close to what you want without having to do that. But I surely would support what you want to do.

Senator WYDEN. We will debate that some more. I think Andy Stern, the head of the Service Employees Union, with their 1.8 million members, has made the case better than I can that the private employer system is sort of melting like a Popsicle on the summer sidewalk. But I will let Andy make that case, too.

One quick question for you, Dr. Frank—and you and Dottie and Frank Baumeister, and Joe Hanson, you did a terrific job in terms of involving people. I think the area that has really resonated with me is, you all seem to have started a revolution in terms of preventive health care, with people coming to those meetings and constantly saying, get us focused on prevention rather than sick care.

Can you elaborate a little bit more on what you heard in the meetings about sort of changing to a whole new ethic of prevention?

Dr. FRANK. Well, much of that came out of the notion of sort of personal responsibility, in part, and creating opportunities for people to actually take better care of themselves.

The way we saw that coming about—and we found that to be very popular with people at our meetings—was through working on a delivery system so those types of services are available locally and come from trusted local provider networks and are available at an affordable rate.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Salazar, you are next.

Senator SALAZAR. Thank you very much, Chairman Baucus. Thank you for putting the spotlight on this issue of health care. I appreciate the excellent testimony from the witnesses.

I have two questions, and I would like each of you to just take a minute in responding to these two questions. The first has to do with the Massachusetts plan. It seems to me that what is going to happen more and more around the country is that frustration in our States is leading our Governors, and everybody else, to basically say, if they cannot get it done in Washington, we are going to get it done back home. That is happening in multiple States.

My question to you is, if you were to take the Massachusetts plan and extrapolate that as a plan that would cover the entire Nation, what kind of costs would you be talking about? Essentially something that gets to universal coverage, but what are the costs that would be associated with that? That is question number one.

Number two, I would like your comments on the President's proposal that he laid out. Some of you have commented on it. You have seen the CBO estimates and other estimates on the cost of that, somewhere around $500 billion, something of that nature. Is it a workable plan? What are the problems with it? If you can do that very briefly.

So I will just start with you, Dr. Mongan, and just come on down the table.

Dr. MONGAN. So with respect to the Massachusetts plan, expanding it to the Nation, if you put all costs in, including the payments people have to mandatorily make, I still believe you are back at that $70- to $100-billion figure.

Incidentally, I would love to sit here and tell the committee, you can do this without any new money. But believe me, to do that you have to surgically extract every bit of waste and abuse in the system; one man's MRI is not another person's waste. Surgically extract it, and then somehow tax it back from the people who are currently paying the premium. So, it will cost money.

Senator SALAZAR. So we could do it nationwide, but you would say it would cost $70 to $100 billion?

Dr. MONGAN. I believe that it would.

Senator SALAZAR. All right. Take a second, then, on the President's plan.

Dr. MONGAN. The second question. With respect to the President's plan, I would echo much of what Dr. Altman said. I think there are some good features there. I think some of those tax features should be looked at. I am concerned about some of the impact

of the HSA provisions in the bill that I think potentially work in a detrimental way towards lower-income people.

Senator SALAZAR. Dr. Altman?

Dr. ALTMAN. Well, you have a number of Massachusetts people here. We have some advantages in Massachusetts, some substantial advantages, that allowed us to do it without sort of breaking our bank. I do believe, in concept, it is the right way to go about building on our current system. I share very strongly Dr. Mongan's view, and I would differ with Mr. Sheils.

I do believe there is enough money in the system. I think Senator Wyden is absolutely correct. But I do not think we can get it. I think it will have pluses and minuses all over the place, and people who want to attack it will put on the front page of every newspaper how particular groups are going to wind up paying a lot more, while others get a lot more.

So I do believe the Massachusetts plan can be a model for the rest of the country, but not necessarily for all States. I share Senator Hatch's comments that some States that have a lot more uninsured and do not have the same structure would not be able to support it, but I do think it is going to cost us about $100 billion initially to cover all the uninsured in the country.

I think we can then squeeze some of it back out, but, if you want to create coverage, you have to recognize there will be a need for some new money initially.

Senator SALAZAR. Mr. Sheils?

Mr. SHEILS. I would say the number would be closer to $50 to $70 billion. I say that because I do not think that the Massachusetts model is going to be successful in covering all Americans.

The affordability issue is really acute with the proposal. They are subsidized to 300 percent of the poverty line. So imagine a woman with two kids, $50,000 income. They would not qualify for a subsidy. A policy for that family would cost something in the neighborhood of $8,700, which is well over 10 percent of their income.

In California, they said, all right, we will cheapen the premium by giving you a catastrophic plan. Well, imagine that, paying 6 or 7 percent of your income and then getting a policy that does not really cover much unless you get very ill.

Senator SALAZAR. So your view of the Massachusetts plan is that, at the end of the day, it is not going to cover everybody.

Mr. SHEILS. I do not believe that it will.

Senator SALAZAR. Because of my time limits here, just a quick sentence or two on the President's proposal.

Mr. SHEILS. The President's proposal does not provide enough subsidies to the low-income people to target that population. We have estimated the average tax savings per family, with $150,000 or more in income, would be about $1,500. For the very lowest income, it would be $35, which is enough for pizza, I suppose.

Senator SALAZAR. Dr. Frank?

Dr. FRANK. Yes. I am in the $100-billion sort of camp. I think that I agree with Senator Wyden, that there is money there. I agree with my two colleagues, that it is really hard to get your hands on it.

Massachusetts. It is important to realize two unique conditions in Massachusetts. One, our rate of uninsured is relatively low, and

we have a lot of Federal money on the table that leveraged what we were able to do. That may not be available everywhere. Those two conditions do not hold everywhere else.

On the President's plan, I, too, am concerned with the fact that it relies so heavily on deductions to cover what are relatively low-income people instead of credits or subsidies, and so I am concerned about that.

I am also concerned, as is Dr. Altman, with provisions that undermine the employer-sponsored system. I just do not think the individual market is ready for prime time yet.

Senator SALAZAR. Thank you.

Thank you, Dr. Frank, for your work with the Citizens' Health Group as well.

The CHAIRMAN. Thank you, Senator.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I do not think anybody has been to more meetings on health care than I have with Stuart Altman, with the possible exception of Max Baucus. I would like to ask Dr. Frank a question. That is about end-of-life care, because your report makes recommendations.

But I have not read your report, so I do not know what they are. I do know this, that an enormous percentage of Medicare goes to that. I do know that when people are dying from long, slow diseases, that, let us say, 3 of the 5 kids are for letting that person go home, take morphine, and just pass.

That is usually what the patient wants, and they can show that by biting down on their feeding tube, and that is usually the only way it happens. But then the doctor, if it is in certain States, cannot give morphine because he would be breaking the law.

So, I mean, it is the whole question of, how do you cut down where I think we can save billions of dollars on end-of-life care without disrupting the concept of what America is?

Dr. FRANK. This is, perhaps, the most surprising thing that we came up with. We were not expecting that to be a major part of our report. Everywhere we went, there was deep concern about this.

Our recommendations really need to be restructured. We identified a number of models that are out there. There is a group at Dartmouth, a group at Rand here, a group at Massachusetts General, Dr. Mongan's shop, who all have developed very sensible approaches that I think would allow considerable autonomy, increased efficiency, allow people a better choice about where they end their days, and it is projected to really save a lot of money.

Senator ROCKEFELLER. How do you do that?

Dr. FRANK. By pursuing these models—I cannot give you——

Senator ROCKEFELLER. I started, in 1989, with Jack Danforth.

Dr. FRANK. Right.

Senator ROCKEFELLER. They called it, at that time, advance directive, or whatever it is now. It is all up to lots of words.

Dr. FRANK. Right.

Senator ROCKEFELLER. But it is on the chart at the end of the bed. Doctors often just routinely ignore it, because they are going to do what they are going to do.

Dr. FRANK. Yes. I think it begins before that. For example, one of the models is, I think, the Good Death model that is really being developed at Dartmouth, and it really starts with a set of supports, a set of education, a set of counseling to the family way before you get to putting the chart on the end of the bed.

Senator ROCKEFELLER. Other comments on that?

Dr. MONGAN. Well, Senator, I would say it is an extremely important, and as you know extremely difficult, area. A very quick anecdote. When I was working here with Senator Long at a hearing on end of life, he was quite intrigued. He called me over and he said, "Maybe we could have a bill." Then he said, "But you don't know when the last year starts, do you?"

In fact, that is the problem not only for drafting legislation, but for doctors. You do not always know that you are dealing with the end of life when you start dealing with the patient. If there is an answer, I believe it is having better connections and primary care to patients.

What we find is that, if the doctor knows the patient ahead of time, they have a much better understanding of their needs and desires as opposed to a patient who just comes in to the emergency room cold.

Senator ROCKEFELLER. I flat-out agree with that. But I have a very hard time accepting that, as you indicate, doctors who know their patients, whether it is Alzheimer's, ALS, or whatever it is, it is one of the more predictable events of life, when life is going to end. Now, how long and when? But this education process or whatever it is you suggest is huge.

What do you suggest beyond the education process?

Dr. FRANK. Well, the model just includes early preparation. Also educating the physicians, getting them to make better prognoses. I think Dr. Mongan is absolutely right.

One of the big problems is that physicians tend to be systematically too optimistic, and so that gives families hope, it creates a desire to intervene more. I think getting more information is important, getting it to be balanced information, both to the doctor and to the patient, because they are both biased in the same kind of way.

Senator ROCKEFELLER. Does that have anything to do—my final question—with the fact that we train so few geriatricians?

Dr. FRANK. There are a remarkably small number of geriatric training programs in the United States right now. In fact, the newest programs are programs to train trainers, just for exactly that reason.

Senator ROCKEFELLER. Thank you, sir.

The CHAIRMAN. Thank you, Senator.

Senator Smith, who has been waiting patiently over here.

Senator SMITH. Thank you, Mr. Chairman. I have been listening and learning much from you gentlemen. I thank you for your contribution here today.

Senator Wyden and I both come from a State that has tried to be quite innovative on health care, and perhaps you are familiar with the Oregon version of Medicaid, the Oregon Health Plan.

I have been struggling with health care as a State Senator, as a U.S. Senator, since 1992, and frankly have concluded—and I

think one of you mentioned, I think it was you, Dr. Altman—that health care is rationed.

You either ration it through price, as we do in this country, or you ration it, as Oregon does on Medicaid, through a package, a defined benefit, or you ration it by denial through delay. It seems to me those are the three models we have to work with.

There is currently in the State of Oregon serious discussion about a new approach, different than Massachusetts. The author of it is the same gentleman who was the author of the Oregon Health Plan, John Kitzhauber. I do not speak for him, in defense of him. I am not representing him.

But if I can give you the outlines of what I understand his approach to be, it would be universal coverage in Oregon that would essentially end Medicaid and Medicare and the employer deduction for health care, to pool those resources and create a defined benefit package for all Oregonians.

I am neither telling you I am for it or against it, I am just open to the idea of how we get a handle on this issue. I wonder if you would have a comment, without knowing more specifics than I am able to give you, on what you would think about that approach.

Dr. ALTMAN. Well, let me comment. First of all, John Kitzhauber is a good friend of mine.

Senator SMITH. And mine.

Dr. ALTMAN. We serve on many panels together and we have been debating his plan for the past 2 years. I strongly believe that Governor Kitzhauber cares a lot, really wants to create a system that will provide basic coverage, believes that the government should do that, and I appreciate that.

My concern with the proposal that he put forward is, if you added up the money that is currently in Medicare and Medicaid and the tax deduction, it comes to about a third of the $2.2 trillion. If that is all you have to provide the basic government coverage, the amount of coverage would be totally inadequate. Dr. Kitzhauber uses the analogy of communities providing basic education for every American. If the public education system spent so little relative to private education, community after community would have an uproar.

So if we are going to do that—and I am not arguing, necessarily against it. I happen to believe I would rather not do it that way—you have to add substantially more money to it. Then we have to take what Dr. Mongan and I say, you have to claw back huge amounts for individuals and providers.

When you sort of do away with the tax deductibility, you then have to tax the people to get the money to spend it. Once you do that, it changes who pays for it in a fundamental way. Second, Medicare is expensive because it covers the sickest people.

Senator SMITH. Yes.

Dr. ALTMAN. So as much as I think John Kitzhauber is one of the most thoughtful people in America, I do not support his plan.

Mr. SHEILS. On the question of rationing, the Oregon plan was an enormous step forward because they took a rational approach to deciding what is going to be covered and what is not. And no offense to people from Oregon, but what they did was ration care to the poor, not ration care throughout the system.

Senator SMITH. Yes. That is correct.

Mr. SHEILS. That would be a big deal. The thought was that if you eliminated, say, heart transplants or liver transplants, you save enough money to provide all this preventive care.

Well, if you were to do that system-wide, you would not have to eliminate as many services to save enough money to provide the other services to the State. That is an explicit form of rationing that extends throughout the State to all who live there. That is fundamentally different. It is rationing. It is explicit rationing and it is very different than what we do now.

But I think that is where you will find more of an answer in terms of saving money without cutting too deeply into the list of services that we do provide.

Senator SMITH. Well, again, Dr. Kitzhauber can speak for himself better than I can. I am not trying to represent the totality of what he is proposing. But as I have understood it, I think he is saying, in order to get a handle on costs, you have to have some kind of a package.

I am attracted to Senator Wyden's bill as well for the reasons that have been stated here this morning, but it does not control costs. But when you control costs, you take away choice. Then above the defined benefit, freedom is there for people to insure above that if they choose to.

Mr. SHEILS. Let me just add that making the care available to all Americans would give you—I am sorry. I am getting old. I will think of it later.

Senator SMITH. I am out of time.

Senator GRASSLEY. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

I certainly appreciate this discussion. It is such a critical part of what we have to do in this country. I appreciate the fact that you all recognize the fact that, without a doubt, it covers many issues, one being the health and well-being of all of our loved ones here in this country, certainly a huge role that it plays in economics, as well as the whole issue of justice, in terms of all being God's creation, that there is an issue of justice in terms of making sure health care is there.

I just want to say, Dr. Frank, thank you. I am glad to see that the Citizens' Health Care Working Group does include the recommendations for improving end-of-life care. I think that is absolutely essential if we are going to deal with this issue.

I also want to echo Senator Wyden's comments on the importance of preventive care, whether it be screening, prenatal. The investment brings us a 10-fold return in the long term. We have to make the investment in order to get the rewards from it, but it is a tremendous investment that does bring rewards, I think both the focus on prevention and proper chronic care management, not just at the end-of-life care, but throughout the life course.

One of the components I tried to work on in Medicare reform was chronic care management, and certainly just simple management in terms of the issues of health care delivery. I think it will be a critical part of keeping our costs down in the long run, and I am grateful for you all's recognition of those issues.

I also want to applaud Chairman Baucus and Senator Grassley in the efforts we have put towards SCHIP. That has been talked about here today. It is coverage that is a critical component in this discussion, hitting on all of those issues, whether it is the long-term cost of health care—if we do not get children the health care that they need early in life, then they are going to continue to become a part of the system that is going to be costly. But it is also the right thing to do. I think that is so essential for us to remind ourselves every day when we deal with that.

A quick question on SCHIP. There are a lot of children in SCHIP who have to drop and go outside of their private insurance. They have insurance, but it is not enough. I would be interested in hearing your comments on the ability of using SCHIP as a wrap-around, much as we do in terms of Medicaid, to be able to take that step if in fact we cannot get to the comprehensive plan that has been talked about.

Then, Mr. Sheils, you raised a good point about the lack of equity in the current distribution of tax benefits. I would be interested to hear about your study. You conclude that 26.7 percent of Federal health benefit tax expenditures go to the 14 percent of the population with the highest incomes.

I believe you are correct in questioning whether it is appropriate considering that the majority of the 47 million uninsured Americans are in the lower-income group, and that is where we are trying to focus our attention in order to get the biggest bang for our buck as we move forward.

So I just would be interested in your comments on whether you think the part of the President's proposal that is working towards that, if done correctly, would really address the equity concerns that you have raised.

That would be kind of my question in terms of the President's proposal, which, again, I am open to looking further into. But I do have some concerns that we may not actually be addressing the issue in the group of greatest concern.

So, those are my two questions, Mr. Chairman.

Dr. ALTMAN. With respect to SCHIP, States have the flexibility of using the Medicaid system or developing their own. As you pointed out, in some areas, by developing their own, they could be restricting the access. I do support the idea of using it as a wrap-around where possible.

There are advantages, though, to having a more restricted delivery system in terms of efficiency and cost, and that is why some States do it. So I think, in general, the Congress was right in giving the States the choice, but the negative is what you pointed out.

Senator LINCOLN. Well, we take more out of the private insurer if they get out of private insurance in order to be able to access that.

Dr. ALTMAN. I know.

Senator LINCOLN. Yes.

Mr. SHEILS. The equity question under the President's plan is really very interesting. It achieves a certain type of equity. That is, if you had two people at identical income levels, one gets employer coverage and one does not, they will both get a tax benefit now. So, it does achieve that kind of equity. The concern is equity across in-

come levels. The lower-income people do not pay enough in taxes to get very much out of a tax deduction.

Senator LINCOLN. Right.

Mr. SHEILS. But if we provided them with a tax credit, a refundable tax credit, we could start to make some progress in directing some funds to that population group. That was originally, I think, the idea that the President had in doing that.

Senator LINCOLN. Just cost.

Mr. SHEILS. Yes. One thing that I would like to add, too, is that administrative costs become an issue with some of these proposals. For example, in Massachusetts they are talking about subsidizing people through 300 percent of poverty. That would require processing 40 million families per year, going down to the health care office and reviewing their income, and so on.

It would cost about $10 billion a year to administer that. If you do it through the tax code, you have a basis for using the model they use with our tax code, which is self-attestation.

You report your income—you report what you spend on health care in this case—and you calculate your taxes. You can adjust your withholding so you can get money put into your paycheck instead of taken out. All of those things are doable. The enforcement in a system like that is, of course, the possibility of an audit and fines for improperly reporting income and your costs.

So I think that using the tax code to generate these tax credits for purchases of private coverage is really the better way to go than doing it where people go in and apply. It would be like going down to the DMV, only worse.

Senator LINCOLN. Well, I have to say, between myself and Senator Snowe working to get the child tax credit refundable, it is a difficult thing to do, but without doing it you really do not get at the heart of the problem. Thank you.

The CHAIRMAN. Thank you, Senator, very much.

I apologize to the witnesses. There is a vote going on, so there is a bit of disruption here.

Assuming we are going to build on the current system—assuming—where would you begin to build? What steps would you begin to take? Anybody. I am going to ask all four, but whoever wants to speak first, just jump in here. Maybe you would like to talk back and forth, too. Let us get a dialogue going here.

Dr. ALTMAN. Well, the value of the Massachusetts plan is that it shows you the places where you can build on. I happen to believe that the employer system should be asked to do more; for better or worse, it is our basic system. We can do more through the employer system.

I do think that, much as I have concerns about pushing the individual mandate too much—and I do think that Mr. Sheils did suggest some problems—I now believe that individual responsibility should be part of any universal access plan.

I do think we need to be very conscious of the fact that we cannot build on it too much, and maybe we should be subsidizing insurance up to 400 to 500 percent of poverty for certain people, or I suggested having a reinsurance system that reduces the costs so that low- and middle-income individuals and families can afford it.

So I would use the Massachusetts approach, which sort of shares the responsibility between government, the individual, and the employer.

The CHAIRMAN. All right.

Mr. SHEILS. I guess I would start with the tax exclusion. I would eliminate it. You could do it without increasing anybody's taxes.

The CHAIRMAN. Just right there, though, do you think that is politically feasible in the short term? I mean, short meaning the next 2 or 3 years, maybe.

Mr. SHEILS. It is amazing. I am amazed that it has been proposed.

The CHAIRMAN. I am, too. In fact, it is refreshing that it has been proposed. But I am just trying to figure out, how realistic is it?

Mr. SHEILS. The only way to do it, I would think, the only thing that would be believable, is to convey to people that we are not trying to raise your taxes, we are just trying to make the tax code neutral. You can do that without raising revenues. The biggest problem with taxing expenditures is you have to pay taxes on income you did not know you had. That is a big problem.

The CHAIRMAN. That is a big problem.

Mr. SHEILS. But if you did it in a way where, look, it is a compact with the American people, you are not going to pay any more in taxes. We are just going to eliminate that exclusion.

I would also talk about making sure people had a choice of health plans. Right now, I think only about half of workers who have a choice of health plans have access to, say, an HMO. Now, that is an option one could put in.

One could also put the HSA options in there. I mean, right now you have to wait for the employer to decide, well, let us do an HSA. If we were to somehow require choice, an example would be taking insurance agents and brokers and require them to prepare a multiple offering for any employer who wants to purchase coverage. That is a way of using the broker rather than thinking in terms of dumping them.

I guess what I would like to see is us just pull out all the stops on the questions of competition. There are so many people who have advocated that you could save money if you would make the system competitive, if you make people face the price of insurance. Most people do not even know what their employer is paying for their insurance.

If you can do those things and create choice in a workable market, competition will have an impact. Whether it is going to be enough to get everything under control, probably not. You would still see costs growing faster than wages, for example.

But I believe in uncorking the system, uncorking all of these ideas on competition before we move to something like rate controls in a single payor system, which has its own broad range of issues and problems.

The CHAIRMAN. All right.

Dr. Frank?

Dr. FRANK. I am going to answer the question about where we would start. I would not start with eliminating the tax deductibility. I think perhaps capping it would be a good idea. I think

that you can do a lot of damage by completely wiping out the employer-based system, so I just want to say that.

I guess the two places I would start would be, first, going after high-cost coverage that is universal, because it is affordable, it is relatively affordable given current budget arrangements, it establishes the principal of universality, and it turns out it is extraordinarily important to small business people.

When we had a meeting sponsored by the National Association of Realtors, over and over and over we heard that, look, the thing that I am worried about is my business, my family, everything being wiped out by a high-cost medical problem, and so the idea of high-cost protection was very popular there.

The second thing I would do is work on the delivery system, just because there is the problem of low-income people having access to all the types of things we have been talking about.

I think right away I would sort of start to build on the community health center concept and move that into the sort of integrated network system to really get effective and efficient systems available to low-income people right away. Then from there you can sort of build a larger insurance thing based on either competition or one of these other models.

The CHAIRMAN. Dr. Mongan?

Dr. MONGAN. Mr. Chairman, if I could make a comment that bears on, I think, your question. You said, assuming we build on the present system. You know, if you look back from about 1970 to 1992, the debate was between radical change—which meant government program, Medicare for everybody, health security, those sorts of things—against building on the present system, which at that time meant basically some government program plus employer mandates or play-or-pay. That was what building on the present system was called.

Now, from about 1992 on, employer mandates had become as problematic as taxes, if you will, in terms of revenue-raising devices. So the debate has shifted a little in recent years towards this individual mandate, which was the key that unlocked the situation in Massachusetts. I guess I would just say, echoing what has been said earlier here, this individual mandate is a tricky piece of business and not necessarily a magic answer.

As you know, there are some on the right who attack it because they do not even want to mandate motorcycle helmets, let alone premium payments. Then there are those on the left who say, gee, are you really going to make people who are still pretty low-income pay this kind of money that could be 10, 11 percent of their income? So, it is not necessarily magic.

Having said that, one of the first two things I would do, I would pick up on this reinsurance or catastrophic concept. Senator Long had a bill 30 years ago that you might take a look at.

Second, I would play with the individual mandate, but again, a little more starting on the kind of catastrophic side so that it is not quite the cost it might otherwise be.

The CHAIRMAN. Thank you.

Senator Stabenow?

Senator STABENOW. Well, thank you, Mr. Chairman. First, I want to just echo what others have said in thanking you for this.

It has been an excellent panel. I really appreciate your comments on putting ideology aside. I think that is so critical for us to be able to look at just what we can do together. So, I thank you for that.

I also want to thank you for your leadership in making SCHIP a priority for us in this committee and, with your leadership, we have made it a top priority in the budget resolution we will be dealing with today.

It is, in fact, just the first step. We have committed to step one, expanding coverage to all children. Obviously, step two is universal coverage. But, thank you for that.

I appreciate the comments and concerns raised about the President's plan related to his tax deductions. Coming from a State with employer plans—we call them Cadillac plans. I drive a Cadillac STS. It is a great car. So I will call it the Cadillac plans.

But the reality is, we have had employers that have stepped up, working with employees to provide insurance. I certainly do not think the first way to cover the uninsured is by taking away coverage of people who have insurance, so I appreciate your comments.

My question to all of you relates to, if we just kind of look at where we go—and you have talked about catastrophic coverage, and I hear that a lot from small businesses and large businesses about starting as a piece to cover catastrophic—but we have systems, as you have mentioned. The reality is, the majority of health care is paid for by public dollars now, directly or indirectly.

So this false debate, this ideology that government should not be involved in health care, is just silly because we provide most of the dollars. So the question is, how do we move forward on universal coverage?

And I would like your thoughts on the structure of Medicare. If you assumed we were adequately providing payments to health care providers—which is a concern right now, just the structure of people paying into a system where they get basic coverage and then they can choose to add coverage and add a premium and copay with Part B for doctor visits and home health care and so on, they can add coverage for prescription drugs—it seems to me that is a uniquely American structure for universal health care that is different than the other systems people criticize, top-down socialized medicine, the kind of thing we hear all the time from people.

Do you think Medicare or some other system we have in place right now provides the right structure in which to work to move towards universal coverage? Dr. Altman?

Dr. ALTMAN. Let me comment. First, let me tell you how much I appreciate what goes on in Michigan. I have spent a lot of time in Michigan and think that there are some very interesting ideas there.

Now, with respect to Medicare, if you compare Medicare to Social Security, Social Security, as a percentage of retirement income, is a much smaller percentage than Medicare.

Medicare really is designed to be, if not the whole, to be a substantial amount of the benefits you will need, particularly with the coverage of prescription drugs, coverage I strongly support.

Even with that prescription drug coverage, Medicare has gaps, there is no question about that: long-term care, certain catastrophic

coverage, and so on. But it is up there. It is not a basic, as Dr. Mongan said, and very limited plan. So you can live without any additional coverage, but most Americans do add extra coverage as well.

I think, as a structure, it is the right one. The fear I have, what Senator Smith talked about, Governor Kitzhauber, if you took his plan, it would give a percentage of health care that would, as I said, be at 30 percent. For the uninsured, it would even be lower.

So I think Medicare needs fixing, but it does not need fixing on its benefit side as much. I think it needs fixing on its financing side, and I do think it needs to be more innovative in terms of not paying for services that are not needed, and so on. But I support the benefits.

Senator STABENOW. Anyone else? Yes.

Mr. SHEILS. I drive a Saturn. I guess I would start by saying that if you were going to maintain or build on the current system of private insurance, you have to do it in a way which will enhance competition.

Administrative costs, according to CMS, for private insurance, grew at about 12 percent a year between 2000 and 2005. Health benefits, health services costs, grew by only 8 percent. How can the cost of the paperwork be growing faster than the cost of the services, when you consider the added new technologies we see?

So I think industry sources say that the profits for health insurance were in the neighborhood of $40 billion in 2006. This came from some Wall Street material, which was actually trying to explain why it is good to invest in insurance companies.

But I do not really mean to pick on the insurance companies. I think it is quite likely a real important part of the answer, but I do feel it is an industry that could benefit greatly from enhanced competition in some way.

Senator STABENOW. Thank you.

The CHAIRMAN. Thank you.

Senator Wyden?

Senator WYDEN. Thank you very much, Mr. Chairman. A question for you, Mr. Sheils. When I was putting my legislation together and I was having town meetings with citizens and the like, what people always came back with is, I want care like you people in Congress have. We want a system like you do, with private coverage and private choices and the like.

Dr. Altman, Dr. Mongan, both of whom I respect very much, talked about all the change in how people would absorb it. But what we sought to do in our legislation is essentially take the 180 million people who get coverage through their employer and essentially take their salary, plus their health benefits, and get them that compensation in cash directly, just their tax brackets, and people would have more cash in their pocket on day one as you go forward with a new system where everybody is covered.

That way the employer wins and the worker wins on day one. The employer does not have to pick up the rate of growth, it is always 11, 12, 13 percent. The worker has more cash in their pocket.

Give me your reaction—I know you do not back legislation and the like—just conceptually to the idea of starting with the worker having more cash in their pocket.

Mr. SHEILS. Well, I think putting more cash in their pocket is there to, again, maximize, uncork, all of the competitive incentives we could possibly get out of the system.

If you put $12,000, which is the average cost of a family policy, in people's wages, individuals are certainly going to think, well, gee whiz, if I save some of this money, if I went to a more efficient plan, not necessarily a grand health plan, I could save enough money to maybe buy a wide screen TV, go fishing in Oregon, whatever you want.

You take away the tax benefit and you give people choice, then I think that you have considerable potential for enhancing the competition in the way it needs to be enhanced.

I think that a prerequisite to health reform, though, universal coverage, will be the idea that people who have money will be able to buy more. That is the way it is all over the world.

In England, there is a private health care system that has evolved. It is like, you pay your property taxes so that we have schools. Well, but you might send your kid to a private school anyway. You still have to pay the property tax. That is what goes on in England, in many cases. People pay for the basic health care system, but they do, at their own expense, use another system.

I think that having a choice, an option to buy more, is really important. I explained to somebody that we are talking about the same benefits as your Congressman has. The family's response was, we want better than that. [Laughter.]

Senator WYDEN. Right.

Mr. SHEILS. So, you might legislate yourself a little improvement here and there. [Laughter.]

Senator WYDEN. I will see if I can get one other one in. That is a very important point. I think there is a clear bipartisan consensus that what universal coverage is about is setting a floor of dignity, and certainly allowing people to have the freedom above that floor to purchase what they want.

Talk to us a little bit more about administrative savings and how you get them. What I sought to do in my legislation is have people sign up once. Essentially once they were signed up, everything would be done through the magical world of withholding, which is different than the last 20 or 30 years. Dr. Altman remembers this so well. We were always talking about vouchers, and putting paper in people's hands.

Could you just—again, not in connection with my bill—talk about the concept of getting people to sign up once and then accomplish everything else through this world of electronic transfers so that people are not going through the time and the cost and stigma of going through this sign-up process continually.

Mr. SHEILS. Well, as I said earlier, you have to think in terms of innovation in administration. You have to think of some new ideas. Right now, the real problem, I think, administratively, is that your coverage is always linked to whether you paid the premium.

You change jobs, well, you have to find another employer to pay your premium, another plan. If you buy down your own, you have to pay the premium. You stop paying, you do not get coverage. That, it seems to me, is the key expense in our system.

The idea in your bill, as it worked out, was that we would collect premiums through a different system—actually, through the tax system—and that would bring in the revenues required to make premium payments to the health plans that people have selected. That is done through the tax code and it is relatively straightforward. But the other step is that the individual goes to the health agencies—kind of a connector—and picks their health plan.

Once they have picked a health plan, once they have reported, they do not have to show whether they paid a premium. They do not have to come in and say, I am low-income, I need subsidies. They do not have to do any of that. All they have to do is come in with a gas bill or driver's license and establish that they are a resident.

Then they pick the plan. They can change plans during an open enrollment period, just like you and I can with the FEHBP, for example. But the system would never let go of you. Just like back at work, if I decide not to fill out the form at the end of the year for open enrollment, I stay where I am. The system will never lose the individual once we can get them into it.

The key to that is making sure that the premiums people pay are collected through another system—in this case, the tax system, possibly have Social Security administer it—and wherein, where you make that payment, there is a worksheet and it says, well, you have low income so you do not pay anything; you have middle income, you do not have to pay the full premium, but pretty much. Then for higher-income people, you just have to pay in the full premium.

So, it is a different and innovative way. There are probably other ways, but I think it has the potential to save us a lot on administrative grounds.

Dr. ALTMAN. Senator Wyden, I wonder if I could just say one thing. When I first started, similar to Dr. Mongan, the administrative costs for health insurance were very small, and the insurance companies did absolutely nothing.

I mean, their job was to keep administrative costs down. They did absolutely nothing. Maybe they had to check on whether you were insured. They did nothing. Then we started asking insurance companies to do a lot more, whether they did it all right or not, the whole issue of managed care and so on.

I do believe you are on to something in terms of savings for the collection of money. I think we can do that with an employer system. I do believe yours would work better, but I do not think that is where the big savings are.

I think the big issue is, what do we want our insurers or our intermediaries to do, just like Medicare? There are three parts to the administrative costs. There is the movement of the money, there is what we ask them to do, and then there are their "profits."

I think to the extent that we can get the profits down, that is appropriate. But I think at the end of the day the question is, what do we ask our intermediaries to do, whoever they are? I strongly believe that we should pool, the way the Chairman said.

I do believe what you are talking about is correct in terms of giving people choice, and you can do that in a variety of ways. So in a lot of ways I think you are on to it.

Whether you need to sort of do away with the employer-based system at the end of the day, if that is the way we agreed, I would buy it. But I think you could get at 80 to 90 percent of what you want by some compromise. So I just want to suggest that we can get almost to what you want without ending the employer-based system.

The CHAIRMAN. And what would that compromise be? What are some of the things that come to mind?

Dr. ALTMAN. If you go down the line of Senator Wyden's bill, I kept checking it off: yes, yes, yes. Competition, pooling, choice. There is so much in there. And as I said at the end, my fear is that if you take away all the taxes and start moving that money around and giving people cash, it is just going to create chaos.

I think we are better served by taking the important concepts that are in the bill and seeing how much we can pull out of our existing system and make it work, and I think we can get pretty far down the road.

Senator WYDEN. Mr. Chairman, can I just do a quick parliamentary thing? You have been so kind to me in terms of giving me this extra time. Dr. Altman, this is a superb panel that Chairman Baucus has put together, and clearly there is going to have to be a lot of give and take in trying to find the common ground.

I would like to just put this into the record, Mr. Chairman. Apparently, Robert Wood Johnson—I am just reading from my BlackBerry—came out with a really important study yesterday, and I will just read it: "Fewer than half of parents and families earning less than $40,000 a year are offered health insurance through their employer, a 9-percent drop since 1997."

So as we work under Chairman Baucus's leadership, I think trying to get our arms around the role of the individual and the role of the employer is obviously going to be key, and you have been very kind. Thank you.

The CHAIRMAN. Thank you. Thank you for how you have advanced the ball here, Senator. It is very appreciated.

Mr. Sheils, you said it was important—maybe it was Dr. Altman, I have forgotten which—to get more competition among insurance companies. My question is, how? How would you do that? In what way?

Mr. SHEILS. Well, I think that the main thing would be to make sure that everybody with employer coverage actually has a choice of health plans. If you are a small insurer, small firm, you are lucky that the employer provides you with one.

But if you were to set it up in a way where your broker was required to present a multiple offering where there were choices and perhaps lower-cost options, in an environment like that you would enhance competition.

As I say, only about half of the firms that offer a choice of plans have an HMO in it. I am not saying we want to put everybody in HMOs, but I am saying we ought to give everyone that option.

I think another thing you need to do, another part of it, is that you need to enhance the incentive for the individual to save the money. If you can create a marketplace where people have strong incentives to buy something less costly, that will be helpful in generating the competition.

Without that, if we continue to numb people to the cost of health care by not even telling them how much the employer is spending, if we continue with that, the incentives to try to control health care are really quite weak. Without that, with the two aspects of it, I do not see how competition will really shoot the lights out for us.

I think health care costs are always going to grow faster than our wages, and that is going to create stress forever. It is happening everywhere else in the world. Every international model I have ever heard of, the people will do it that way. They are facing pretty much the same problem.

I do not think it is reasonable to think that we are going to get all these new innovations and modern medicine without paying for them, but I do think we can get into an environment where we can possibly slow the rate of growth in health care costs.

The CHAIRMAN. Right.

Mr. SHEILS. Maybe half a point a year. After a few years, that really accumulates. So, compounding, you save quite a bit of money.

So I encourage people to think in terms of those two pieces: increasing choice and increasing the incentives to make lower-cost choices.

The CHAIRMAN. How important is it that we try to solve this basic problem of coverage and cost? Is this just an exercise just to go through, an academic exercise, that, sure, it is interesting, it is helpful to try to find a solution, but we are the United States of America, we are a big, strong country. If we do not get this solved significantly, no big deal.

Or on the other hand, is this a big deal? If it is a big deal, if you could fairly and precisely articulate the reasons why it is a big deal that we try to begin to solve this. How important is it? That is the basic question.

Dr. MONGAN. Could I take a quick jump?

The CHAIRMAN. Sure.

Dr. MONGAN. Senator, as I tried to indicate in my testimony, I think the coverage issue is a very big deal, a very big deal for people's health, a very big deal for the economy, and a very big deal for the kind of just society we want to be. So, I think it is critically important.

I think the cost issue is ultimately important, again, in terms of what kind of society we are going to be. I think we have to be real careful with the cost issue. We are a wealthy society. Some make the argument that, in fact, we could continue to afford some continued increases in cost, but at some point you get to a place where I think society is going to have to say "enough" because the imbalance between health and other expenditures will just be too great.

So I think, ultimately, both of them are critical issues. The coverage issue is one that I think is absolutely compelling, and the cost one will be compelling as a piece of finishing the whole puzzle.

The CHAIRMAN. Just playing the devil's advocate a little bit, I hear a lot from businesses who are very concerned about the costs from a competitive perspective. Let me put it this way. Last year, I took a bunch of Montana businessmen to Asia and Bangalore—first China, then India.

In Bangalore, I went to the Jack Welch Technology Center. It is a big research facility, one of the three GE research facilities in the world. It was very impressive. When I finished, I went to talk to the manager, the only non-Indian there. An awful lot of folks there.

I said, "Why are you in Bangalore?" He said, "The greatest talent pool." I asked, "What country has the next greatest talent pool?" "China." "Where are we, the United States?" "Oh, you are kind of down there." "What does it take for us to get up there?" I asked.

His immediate response, without skipping a beat, was education and health care. He said, "You have to educate your people better, and you have a health care system that hurts your companies doing business." I am just curious the degree to which anybody might agree with that.

Dr. ALTMAN. Let me comment on that. I have worked a lot with business, and I totally agree that it does put those companies that really are——

The CHAIRMAN. And sort of duck Mr. Sheils's point about an employer-based system, those poor companies who have to pay these big bills.

Dr. ALTMAN. I mean, that is what the issue is. But what I have found—and maybe you have a different view—I have not found business willing to step up to the plate to raise taxes.

The CHAIRMAN. Oh, I agree with that.

Dr. ALTMAN. And so it is easy. With all due respect to them, they talk in not a complete sentence. So the question is, can we help them? Should we help them? The answer is yes. That is why I have advocated the reinsurance system across the board. I think that would help them.

I was pleased to see Professor Frank say the same thing. I think we can do that. As I said, the business community does not talk in a complete sentence, and they have not been willing to step up to the plate and say, fine, take it off our backs, we will gladly support a tax increase.

The CHAIRMAN. Dr. Frank?

Dr. FRANK. Yes. I just want to first address your first question, which is, after trouping around the country for about 2 years, the health care system regularly breaks people's hearts. We just heard it over and over again.

One fellow said to us—I think it was actually in Salt Lake City—you know, my business, my life, my assets were gone in the blink of an eye. This happened—I cannot tell you how many hundreds of times we heard these stories. Small businesses are feeling that, too.

Now, I do have the observation, putting on my hat as an economist, that the times that we have made the most progress on the uninsured in recent history have been one of the times when we reigned in the costs. During that period during the 1990s where managed care, as bad as people thought it was, really brought down the rate of growth, suddenly we started making inroads on the uninsured.

So I think you are right, that you have to, at some point, reconnect those. But I think there are things to do. I again go back to my colleagues and agree with them strategically, that at the end of the day I think you need to address the cost side as well.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. I was just going to ask one other question, and I appreciate all the time.

Dr. Frank, what did you pick up as you all went around the country with respect to people getting information about the quality of services and the cost of services? I hear this constantly from everybody. I mean, the reality is, you can learn a lot more about buying a washing machine than you can about health care.

What were your recommendations with respect to this whole question about getting comparative information so you can make health care choices more wisely?

Dr. FRANK. Well, I think, clearly, we support that. We think that information is important. The new capabilities of health information technology should improve that.

One of the things that we heard over and over, was that people really depend on sources very close to home for information, their doctors, the health care systems, and it is very hard for them to get a straight story there.

Creating opportunities to have better communications, to make things clearer, to use information technology to tell people what is going on in a transparent way is very important to people.

Senator WYDEN. Mr. Chairman, you have given me a lot of time. I think Dr. Frank's point there, especially for those of us who have big western States and rural areas, is going to be key. What we were trying to do, and picked up to some extent on what I heard going to your meetings, is to try to say that this information ought to literally be available by zip code.

In other words, people want to know close by in Oregon and Montana and Colorado what kind of doctor offers what sort of service, and what their track record is, and to the extent you can, in something resembling English, some information. So, you are on to a good thing. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Salazar, I do not know if you want to ask some questions now or not.

Senator SALAZAR. Yes, Mr. Chairman.

The CHAIRMAN. Because if you do not, I am sure Senator Wyden will. [Laughter.]

Senator SALAZAR. No.

The CHAIRMAN. Go ahead.

Senator SALAZAR. I would like to ask a few more questions on the President's plan, in part because my colleague, Senator Wyden, has encouraged me to join with a group of Senators on a bipartisan basis to have a dialogue with the White House on how we might move forward in some way.

I will say this. I think that both Senator Baucus and Senator Wyden are correct in making the statement that we ought not wait until after the 2008 presidential elections, that we ought to do as much as we can at this point in time. We are having a series of dialogues with the White House, and who knows where we will ultimately end up.

But I think in the earlier set of questions where I asked each of you to respond in 30 seconds to the question I asked you, basically

I think at least a couple of you said that your concern with the President's plan was two-fold, if I could summarize it correctly.

One, that it does not provide enough deductions for low-income people to afford coverage, and that a tax credit will be more effective. I think, according to the analysis that has been done of the President's plan, I think even the President's own figures show that we would only take care of some 7 million of the uninsured, knowing that we have almost 48 million uninsured, so it is only going to take care of a small percentage of the problem with the uninsured.

Then the second concern that I heard from some of you is that it would erode some of the employer-based health insurance system by creating incentives for healthy people to forego the insurance offered by the employer.

Because this is the agenda, at least, for health care that the President set forth in his State of the Union, I would like you to elaborate on the concerns that you have from your expertise and your point of view with respect to the plan.

Dr. ALTMAN. There is one of the pieces of the President's plan that we did not talk about that is very problematic and very difficult to figure out, and that is the role of the "safety net" providers if we were to go closer and closer to universal coverage.

To say we have a safety net system is sort of pushing it a little bit, but we do have a number of important deliveries of care that disproportionately provide care to the uninsured and to Medicaid, whether they are public hospitals, neighborhood health clinics, or any not-for-profit or even for-profits that wind up in areas.

The President's plan would systematically reduce payments to them and take that money and use that to cover the uninsured. To some extent, that is appropriate.

However, if you look at what happened in Massachusetts—and I do not want to overdo Massachusetts—the framers of the plan—and it was not me—did take money away from the safety net providers to cover some of the costs, but they were very conscious of the fact that these providers provide services that, even in a truly universal coverage system, need to be there because the uninsured are not just like us and have less money. Some of them need different kinds of services, and an insurance system will not pay for it.

So I became concerned, when you look at that part, that it did not do justice to the safety net providers. So I would just put that on your agenda to look at.

Senator SALAZAR. All right.

Mr. SHEILS. I would just say that the President's plan, a feature of it is, the tax deduction you get applies to whatever insurance you buy, whether it is employer insurance or non-group insurance. So in that sense, it is rather neutral to whether or not you have employer coverage or non-group coverage.

What we believe will happen is, in the long term, groups will sort of sort themselves out. Where it is cheaper to have employer coverage—and it will often be the case, with much lower administrative costs for larger firms—certainly, in those cases I do not see any reason for employer coverage to disappear.

In cases where people can do better, where the group could actually go out and buy the coverage at a better cost in the individual market, for example, in those cases—and it depends on how the market is structured—people will, I think, dump employer coverage. We estimated about 12.1 million workers and dependents losing coverage under that provision.

There is still a net increase in the number of people who are covered. Most of the people who drop that coverage, we estimate most of them will get coverage somewhere else—private coverage, and some on Medicaid. But I think you are right that there would be an erosion of employer coverage, but there would be a limit to it. I do not think it would go beyond the 12 million persons we estimate, for example.

Senator SALAZAR. Dr. Frank?

Dr. FRANK. What I am concerned about is, as you said, a lack of subsidy or tax credit to actually put money in the hands of people who are poor. A deduction does not do you much good when you do not pay taxes.

The other piece, though, is that when you start to—I do not have any trouble de-emphasizing the employer-based system if you have a good pooling alternative. Now, Senator Wyden's plan pushes us in the direction of an alternate pooling mechanism. I did not see that in the President's plan. Betting on the individual market, I think, is a bad bet.

Senator SALAZAR. May I, Mr. Chairman, just ask another question? The President's plan essentially has been characterized by some people as costing somewhere in the neighborhood of $550 billion in order to implement. I am wondering, at the end of the day, about trying to figure out how you put the fiscal picture together so that it makes sense for the country. Senator Baucus is struggling now, as we are struggling to try to figure out how we finance SCHIP and how we expand that.

But in terms of where the dollars would come from for say—some of you mentioned it would cost $100 billion to be able to expand the Massachusetts model and extrapolate that across the country. What would be your suggestions in terms of where that money would come from?

Dr. ALTMAN. Well, first of all, I think the $500 billion, I am not sure. I think that is over a 10-year period of time——

Senator SALAZAR. It is.

Dr. ALTMAN [continuing]. Where the $100 billion is over a year. So I do think we should recognize that the President's plan, because we do not think it does that much, is also much less expensive. And at the end of the day, I must go back to the comments made by the Chairman. I think we need to deal with the cost issue at the end of the day. I would prefer we deal with it when we get everybody covered.

I think, while it may cost money in the short run, and I do not want to minimize that, I think in the long run we need to get our rate of growth down, not to a point where it is the same as the CPI. I think that is silly. Mr. Sheils made it very clear, we will spend more, and we should spend more, and Americans will react.

So, I think we just have to recognize that it is quite likely to cost more in the beginning, but over time I think if we do the right things, we can ultimately spend less.

Senator SALAZAR. Can I ask you a similar question on that, Dr. Altman? When will we know whether this Massachusetts experiment is working and what the costs are? I mean, it is a new program. Two years out? A year out?

Dr. ALTMAN. We are hitting a very important issue in time. In July of this year, the individual mandate goes into effect. We have this group of very talented individuals who run this thing called the Connector, which is trying to grapple with the idea of, how do you make this affordable to the group that Mr. Sheils talked about?

While I agree with him, not everybody is going to take this. First of all, people do not know about what is required. They still do not know it. This is not your group that picks up the *New York Times* every morning before they go to work. They are working hard. They have three jobs, and so on.

So, we are going to find out after July. It is going to take time. I think it would be unfair to sort of say, by August, September, or even a year from now, well, it has failed. I think we are going to need to give it several years to work itself out.

And even if we do not get to 100 percent, the State is making sizeable improvements. The number of people setting coverage at below 100 percent of poverty is increasing. The number of people between 100 and 300 is increasing. At the end of the day, we need to evaluate this in comparison to what would have happened had the State not done it.

Senator SALAZAR. Well, thank you, Dr. Altman.

Dr. MONGAN. Senator, since I started my testimony with a comment about financing, you asked a very fair question: who is going to pay? Basically, people are going to pay. It is going to come directly out of people's pocket for a mandated payment.

It is going to come from the employer, which most economists think means it is coming from the person's wages, or it is going to come from taxes, which comes from people. Which way it comes will affect greatly which people are impacted, but it is going to come from people.

I know, Senator Wyden, I am tremendously committed to your concept that the best way to do this would be to get the waste and the abuse out of the system and pay for it without any new dollars.

Again, the complexity of surgically excising that waste out and then having to tax it back from the person who paid the premium, I think you are still taking it out of people's pockets. That is where it is going to come from.

Senator SALAZAR. Thank you very much.

The CHAIRMAN. Thank you, Senator.

This has been a very good hearing. I want to thank you very, very much. It has been thoughtful. I appreciate this very much. I personally believe we have to move very quickly, as quickly as we can, as complicated as this problem is. Health care is a right, it is not a privilege.

Health care should not be treated as a commodity. This is something that is basic, a core value of America. We are just going to have to jump into this. I am reminded of a poem. This shows how

masochistic I think we are. The poem is at the beginning of a book about law school. It was by Columbia Law School. It was Karl Llewellyn, I think, who wrote this book a long time ago.

The preface of this book—and we all know the theme—"I jumped into this bramble bush and scratched my eyes out. I was blind. I could not see. I jumped back into the bramble bush and scratched my eyes back in, now I can see." We are going to have to do a lot of jumping into a lot of bramble bushes to make this thing work. [Laughter.]

Thank you very much. I appreciate your time.

[Whereupon, at 12:16 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Testimony of

Stuart H. Altman Ph.D

Dean and Sol C. Chaikin Professor of National Health Policy
The Heller School for Social Policy and Management
Brandeis University

Before

The U.S. Senate Finance Committee

March 14, 2007

Good Morning, Mr. Chairman and members of the Committee.

My name is Stuart Altman. I am the Dean and Sol C. Chaikin Professor of National Health Policy at The Heller School for Social Policy and Management at Brandeis University. I appreciate being invited to testify before you this morning on the critically important subject of the need for national reform to develop a system to provide comprehensive health insurance protection for all Americans.

This subject has been central to my professional activities for the past 36 years. I have had the privilege of working on this issue both as a federal government official---Deputy Assistant Secretary for Health Planning and Evaluation for The Department of Health, Education and Welfare, 1971-1976 and Chair of The Prospective Payment Assessment Commission, 1983-1994 --- and for various State governments. I also worked on the healthcare transition team for President-elect Clinton and helped design the health reform plan for Senator Kerry in his bid for the U.S. Presidency. Unfortunately, as you well know, the U.S. has not found the right approach to solve this problem and the number of uninsured keeps growing.

Clearly, the 47 million Americans with no health insurance bear the greatest burden of not having such protection, but the negative implications of this situation go far beyond these individuals and their families. Lack of a true universal health system for the US has serious negative implications for many businesses both in the domestic and international markets. It creates financial problems for those health providers that provide care to large numbers of the uninsured, it raises the cost of private health insurance premiums, and it distorts the labor market decisions of many workers. I will focus most of my testimony this morning on a discussion of these problems.

Before discussing the wider negative implications of the lack of a universal health insurance system, I must admit that for me and the many others who have tried over the years to remedy this situation it has been frustrating to recognize that our lack of success is inconsistent with the views of the American people. In survey after survey, the vast majority of Americans believe we should have a national system to protect all of us against the high cost of health care. Yet we can't seem to make it happen.

As I have watched and participated in the many attempts to pass universal health insurance I have reluctantly developed what I now call Altman's Law, to explain why the US has not developed such a system. Altman's law can be summarized as follows:

"*Almost every American and advocacy group supports some form of Universal Health Insurance-- But if it's not their preferred version, their second best alternative is to maintain the status quo.*"

I truly hope that the work of this Committee can help repeal Altman's law.

I know that this hearing is not designed to discuss the technical details of how to create a universal health insurance system, but permit me to make two general observations.

1. There are many ways to protect all Americans against the costs of expensive healthcare and each brings with it certain advantages and disadvantages or "winners" and "losers." I strongly believe that we substantially improve the probability of legislating a comprehensive health reform system if we build on the current financing system as much as possible. To do otherwise generates significant opposition from groups that are key players in the existing system. Because they have a lot to lose, they form

alliances with other "loser" groups to derail such legislative initiatives.

2. Much as I support the need to both protect all Americans and to reduce the growth of healthcare costs, I think it would be a big mistake to combine both in the same legislative reform plan. Each component requires changes from the current system that will be opposed by some if not many influential groups. It is also unlikely that combining the two will generate enough new support to counter the combined negative forces that will oppose the coverage and cost control legislation. Since I believe it is both easier and more important to provide comprehensive coverage I would start with solving that problem.

The new Massachusetts health reform plan adopted both approaches by focusing its first effort on developing a universal coverage system for the state and then asking a commission to recommend changes to lower costs and improve quality. Similar approaches are being discussed in several other states including California where Governor Schwarzenegger has proposed a plan that has many of the same components as the one legislated in Massachusetts. States are the true laboratories for change and permit different approaches to be tested. While I believe, in the end, we need a federal reform system, we should encourage more states to develop their own approaches and, where possible, receive substantive and financial help from the federal government.

In order to build a reform plan on our current healthcare financing system, we must rely heavily on the employer-based private insurance system. With the cost of a family health insurance policy exceeding $12,000 in parts of the country, we must do something to lower premiums if we are going to ask employers and employees to share the cost of expanded coverage and help them

compete in international markets. My suggestion to accomplish this is to have the federal government help underwrite the cost of care for the most expensive patients through a governmental re-insurance system. For example, the federal government could reimburse a private carrier for 75% of the expenses for all patients whose costs exceed $100,000. If you wish to limit the federal expense of the plan it could be limited to firms that have a low wage labor force or those for which health insurance premiums exceed a certain percentage of revenues. By enacting such a re-insurance system, we would be asking all of us to share in the financial burden of caring for the very sick, not just a small subgroup of the population that happens to work for the same firm. This would be especially helpful for small and medium sized companies.

Under this approach the government could also require that as a condition of participating in such a plan, a private insurer must demonstrate that they operate an effective "high cost case management system" (HCCMS). When used correctly HCCMS have been shown to both improve the care provided to the neediest ill patients and lower the overall cost of care. Given that about 70% of the cost of care is for the sickest 10% of the patient population, focusing on this group could have a substantial impact on overall healthcare spending.

Negative Implications of Lack of Universal Healthcare Coverage

Although 47 million Americans lack health insurance coverage at any moment in time, millions more lack such protection at some time during a year, or have inadequate insurance protection. When these individuals get sick, they often receive care in the emergency room, the most expensive place to get treated, or wait until they are very ill and require catastrophic intervention . What they lack is preventive and primary care. I am sure Dr. Mongan can give you numerous examples of patients that received extensive amounts of

health care in one of his hospitals and paid nothing or very little for the care. Fortunately, Massachusetts has a free care pool that helps healthcare institutions pay for such care. But the money to support this pool must come from somewhere. For the most part, the somewhere is the hospitals and health insurance plans who then raises their prices to employers and everyone else. In essence the U.S. has created a "hidden tax" that disproportionately falls on other patients and some of the insured. To the extent that health providers cannot shift these expenses to others, they must absorb them and try to lower their other expenses or reduce care to all their patients. If the care given to the uninsured were spread evenly among all health providers, it would not pose a serious problem. But, as we well know, a relatively small number of providers bear much of the burden, and it is just those providers that have the toughest time shifting the expenses to others. These so called "Safety-Net" providers are often the institutions that are the most strapped for funds to improve the quality and safety of the care they provide. But the burden goes beyond the traditional safety net institutions and has led to serious negative financial consequences for both not-for-profit and for-profit institutions throughout the country.

A related but equally serious negative consequence of our patchwork health insurance system is its effect on those employers that do provide comprehensive benefits to their workers and their families. Most of the large manufacturing companies in the U.S. have traditionally provided such benefits, and they now find themselves responsible not only for the health insurance costs of their workers but also for other dependents (many of whom work for other companies who limit the coverage they offer). In addition, some of these companies have made long-term commitments to their retired workers and provide benefits not covered by the normal Medicare program. Ironically, these are the employer-sponsors that are forced to pay the largest hidden tax to cover the expenses of the uninsured.

Because these companies have been in business for many years, their work force is older and their experience rated premiums are higher than a company that has recently entered their industry. This has had especially negative consequences for our more established companies in the auto, steel and airline industries (or for governments at the state and federal level). In the case of automakers, for example, the established U.S. companies must add several hundred dollars of costs onto each car in comparison to foreign owned companies that have recently begun to manufacture cars in this country.

The problem for our U.S. companies is even worse when they are required to compete in the global economy with companies from other countries. Not only is it a fact that we spend two to three times more for health care on a per capita basis in comparison to other industrialized companies, but given that we finance this care in such an uneven manner across the various sectors, our major manufacturing companies that provide comprehensive healthcare benefits are at a distinct cost disadvantage.

Finally we come to the negative consequences to individuals in their choice of who to work for and where to live. Because of the uneven nature by which firms provide comprehensive benefits, workers who are otherwise unhappy with their job may be forced to stay with an employer primarily because of fear of losing needed health insurance coverage. This is bad for the individual and reduces the ultimate productivity that flows from a flexible workforce. Similar problems occur in terms of choosing what geographic area to live in. It is well known that the backup healthcare protection provided by states varies substantially. It is also true that companies that operate in certain geographic areas traditionally provide better health benefits. Although choice of where to work or where companies choose to locate are individual decisions, incentives created by our patchwork non-system of

health insurance distort such decisions in ways that have negative personal and economic consequences.

Summary

In summary, the need for national health reform becomes stronger every day. For the tens of millions of Americans with no or minimal health insurance coverage, the negative consequences are personal in terms of going without needed care, waiting too long to seek care, impairing their health status and incurring economic hardship because of large medical expenses. Whether they ultimately pay for their care or are forced into bankruptcy because of unpaid medical bills, the negative effects on individuals and their families are substantial.

In addition, there are serious negative consequences that affect many other components of our society. Those employers who do provide comprehensive benefits to their workers and families are forced to pay a hidden tax to cover much of the cost of care that is provided to the uninsured. This negatively affects their competitive position vis-à-vis other companies in this country that do not provide comparable benefits as well as with those competitors in international markets. Those institutions and healthcare professionals that provide uncompensated care to the uninsured and can't pass the cost on to others must forgo needed income and/or cut back on the care they provide other patients.

Providing needed reform will not be easy but failure to act will only make the problems worse. We must find the right combination of techniques that will ultimately provide all Americans with adequate healthcare coverage and reduce our spending rate to make universal health care affordable.

Thank you Mr. Chairman for the privilege of discussing this most important social and economic problem before your committee.

Answers to Questions Submitted to Stuart H. Altman from the Public Hearing of The United States Senate Committee on Finance "Charting a Course for Health Care Reform: Moving Toward Universal Coverage" March 14, 2007

Chairman Baucus

Question for the Panel

It seems clear that universal coverage is in everyone's best interest and has a lot of support. Yet I think anyone who follows health policy would agree that we've been here before—more than once—and yet the number of uninsured continues to grow. What is the biggest roadblock to reform? Is it the costs, the politics, the complexity of the current system, some combination of these factors, or something else entirely?

After studying the issue of why the U.S. does not create a universal coverage system for over 30 years, I have come to the conclusion that, while most Americans believe that all Americans should have some form of health insurance coverage, when we try to develop the type of plan to implement such coverage, too many citizens and politicians would rather maintain the status quo than support a particular system that they do not support.

Why they don't support a particular system is mostly on the financing side—who will pay the bill? Strong philosophical issues surrounding the role of government also play an important role. My own belief is that, with all the complaints about the current health financing system in the U.S., unless the middle class really feels threatened that they could lose their own coverage, they will not support a change in our system that they feel could negatively impact on them.

Question for the Panel

Are American businesses prepared to make sacrifices to have universal coverage?

It is not clear to me that American businesses are prepared to make any sacrifices to have universal coverage. Quite the opposite. Each subgroup of the business community is looking to reduce what they now pay or believe they would be required to pay if legislation was enacted.

Question for the Panel

In contemplating reform, the stakes are high, and there is tremendous room for error. We do not want to waste time, energy, or lives going down the wrong road. What should we be mindful of when changing the status quo? Can each of you

identify pitfalls that we must avoid? What lessons can we learn from past unsuccessful health reform efforts?

There are several key issues.

(a) Possible negative consequences for some existing groups while we improve coverage or lower costs to other groups. This issue is the one most used by critics of the various reform plans that have been circulated in the past, particularly the one put forth by the Clinton Administration.

(b) As an alternative to hurting any existing group, some proposals just add new spending by the Federal Government for covering new groups. Of course the losers under such plans are the taxpayers.

(c) A final and perhaps most negative consequence of a possible reform plan is what impact (negative) that it might have on the U.S. health care delivery system. The various funding mechanisms we use to pay for care are strongly interrelated to the structure, size, and quality of the health care delivery system. Often system reformers tend to minimize any negative consequences their plan might have on the health care delivery system.

Senator Kerry

<u>Question for Dr. Altman</u>

You suggest reinsurance as a way to keep the cost of premiums down. I am currently working on legislation that would create a Federal reinsurance program. Why do you think that reinsurance will help small businesses with the cost of health care? Do you think reinsurance would help employers in the auto, steel, and airline industries that have older workers?

I believe the Federal Government can play a very constructive role in lowering health insurance premiums for all types of policies by helping to pay a portion of the expenses for very high cost patients after a threshold, i.e. $50,000, has been past. This program could be available for all types of businesses, thereby helping large auto, steel, and airline companies or could be targeted to only small businesses or only firms with a high proportion of low-wage workers. Such a plan has many advantages. It shares the cost of a relatively few sick individuals over the entire population, thereby not forcing a small subset of the population (individual firms) to pay the full cost of such expenses. In so doing, it eliminates the need for firms to be concerned about (discriminated against) a particular worker or family member who has large medical expenses or has the potential for high medical costs in the future. It also minimizes the same potential discrimination by a health plan. Such a plan has the potential to lower overall health spending by requiring the government or the health plan to focus its efforts on lowering the cost of

providing care to very sick patients by working to eliminate unnecessary or marginally useful care.

Question for the Panel

My top three health care priorities this year are extending coverage to as many uninsured kids as possible, addressing the small business health care crisis, and pursuing a Federal reinsurance policy that will reduce premiums and stabilize the group purchasing market. Can you comment on the extent to which each of these will lay the groundwork for broader reform initiatives we consider this Congress and beyond?

As indicated above, I think reinsurance can both lower overall medical spending and if focused can really help small businesses by lowering their premium costs. Such savings could also be used to help fund expanded coverage for uninsured children.

Question for the Panel

Mr. Sheils mentioned in his testimony that the U.S. is currently spending $6,500 per person, which is nearly twice the per-capita spending in Canada and most European countries. The delivery of our health care is uneven—not all patients are treated the same. What can be done to reduce the cost of health care and to provide more equal care to patients?

We have known for a long time that health care utilization patterns vary widely in different geographic regions. Unfortunately we have done little to change these patterns. I think we need to develop new forms of payment policies that establish rewards and penalties for higher or lower utilization rates after adjusting for differences in the types of patients treated in each region.

Question for the Panel

I am concerned that, in order for companies to be competitive, they are reducing their health care benefits or increasing the employee's share of the premiums. Do you see evidence of this trend, and is it a trend that will continue?

The latest figures I have seen suggest that the amount of out-of-pocket funds paid by employees or higher premiums charged to workers has leveled off. Also I was pleased to see that the proportion of workers who are offered and take an employer-sponsored health plan has leveled off after falling from about 69% to about 58%.

Question for the Panel

Are we adding to our health care costs by allowing the number of the uninsured to continue to grow? Are health care costs often high for those without insurance

because they usually do not receive preventive care and do not seek medical care until their health problem has escalated?

We clearly add to some portion of health care spending by having large numbers of uninsured Americans who do not seek either preventive services or wait until their illness has become more serious. On net, it would require some increase in overall spending to include all Americans in the coverage category. Estimates are between a 5- and 8-percent increase in spending to cover the 47 million Americans with no health insurance coverage.

Question for the Panel

Recently, the *New York Times* published a survey which showed that 60 percent of Americans would be willing to pay more in taxes in order to guarantee health care for all—including 46% of Republicans polled. Do you think a revenue increase is an appropriate way to finance expanded health care coverage? Do you have other suggestions on how to finance expanded coverage?

I think we should think about adding some earmarked revenue for expanded coverage. Once everyone is covered, then we should focus attention on reducing overall spending.

Senator Kyl

Question for the Panel

One thing I didn't hear the panel mention is the tax treatment of health care. Do you agree that Congress should examine the tax treatment of health care, particularly the more favorable tax treatment for an individual who receives employer-sponsored health coverage compared with an individual purchasing health coverage on his own?

I do believe we should level the playing field between what individuals receive through an employer-sponsored plan and if they buy coverage individually. I am opposed however to reducing the tax advantages of purchasing health care coverage through an employer.

Question for Dr. Altman

You propose that the Federal Government underwrite the cost of care for the most expensive patients through a governmental reinsurance system. Are you recommending a Fannie Mae/Freddie Mac style system for health insurance? Approximately how much would a reinsurance system cost? Would it utilize existing Federal dollars or require additional revenue? And, can you please explain how

such a proposal protects taxpayers and helps ensure the United States' long-term financial stability?

As indicated in my answer to Senator Kerry, I strongly favor a government-supported high case cost reinsurance system. While it would add to Federal expenditures, I think it would both improve the functioning of our private health insurance system and ultimately lead to lower health care spending.

Senator Cantwell

Question for the Panel

QUESTION ONE—WASHINGTON'S HIGH-QUALITY/LOW-COST CARE

My home State of Washington has long been recognized as a high-quality, low-cost health care State.

You all are no doubt familiar with the Dartmouth Research showing that there are wide regional variations in Medicare spending and that they are unrelated to health care outcomes. In other words, we spend a lot more money in some parts of the country than others, but we don't get better care for it. In fact, some of the highest quality care States in the country are among the lowest-cost States.

Residents of high-spending areas in the country receive as much as 60 percent more care than those in low-spending areas. While the researchers say high-spending areas have greater frequency of physician visits, more frequent use of specialists, more frequent tests and minor procedures, and greater use of the hospitals and intensive care units, they find no evidence that people in high-spending regions have better health outcomes or are more satisfied with their care than people in lower-cost areas.

What are your suggestions for tackling the wide regional variations in health care spending?

Should high-quality, low-cost States like Washington continue to be penalized by a system that rewards inefficiency with more reimbursement?

What do you think other areas of the country can learn from an efficient health care State like Washington?

I think lower-spending, higher-quality of care areas such as exist in certain areas of Washington State should be financially rewarded, while high-spending, lower-quality of care regions should face reimbursement penalties.

Question for the Panel

QUESTION TWO—BIPARTISAN LEADERSHIP ON HEALTH CARE REFORM

I recently joined with a number of my colleagues from both sides of the aisle, including Senators Wyden, Conrad, Salazar, Lott, and Crapo, in committing to work in a bipartisan way to tackle health care reform. There have been a number of diverse outside groups coming together as well around the need for health care reform, including employers, providers, advocates, and others. Many States have stepped up to the plate on reform, including my home State of Washington, which recently passed significant legislation to cover kids.

What advice would you give to my colleagues and me, who want to work together on achievable solutions? What is the one thing that we could do this year, in addition to reauthorizing SCHIP, that would make a measurable difference?

What is most important to States trying to reform their health system and expand coverage is financial help from the Federal Government and greater flexibility by the Federal Government in how States can use existing health care dollars. Without the help of the Federal Government, the State of Massachusetts could never have undertaken its health reform plan. In contrast, some of the current policies being advocated by the Bush Administration in limiting the spending of Federal funds could jeopardize the future of the State's health reform plan.

Question for the Panel

QUESTION THREE—BUILDING ON EXISTING PROGRAMS TO EXPAND COVERAGE

Several of you talked either in your written statements or in the question and answer session about State reform efforts. Washington State has been a leader in building on existing public programs to expand access to increasing numbers of the uninsured. In fact, our State recently passed legislation to cut the number of uninsured children in half.

Can you talk about how States are leveraging existing programs to expand coverage and the importance of building what we already have in place to achieve broader coverage?

I think it is critical that we try to build on our current system as much as possible. While our existing system is far from perfect and needs a number of adjustments to make it work more fairly and at lower costs, I believe a total redo of the system is not politically viable and could easily lead to more problems than we now have. Massachusetts offers some good examples on how to build on the current system.

Statement of Senator Bingaman
Finance Committee Hearing 3.14.07

Let me thank the Chairman for holding this very important hearing. It is critical for this Committee to take a serious look at the ever-growing problem of America's uninsured.

Today, nearly 47 million Americans are uninsured, many of them in working families. As we continue to debate the issue here in Congress, this number continues to grow.

Ironically, the problem of the uninsured does not arise because we expend less national resources than other countries on healthcare but rather, it arises because of inefficiencies within our healthcare system and lack of political will to provide universal coverage.

As a country we continue to spend twice as much of the rest of similarly situated countries on healthcare. Astoundingly, we spend nearly half a trillion dollars more on healthcare—yet we have tens of thousands of uninsured Americans and these other countries provide universal coverage.

The time for Congress to act is now. We must begin seriously to tackle this issue.

I would like to underscore the importance of our existing federal and state-based healthcare coverage through Medicaid, Medicare, and the State Children's Health Insurance Program or "SCHIP." These programs serve as a vital source of coverage for many of America's most vulnerable populations including our low-income families as well as the elderly and disabled.

SCHIP, in particular, has proven very successful at insuring America's working poor. It's a vital program and reauthorization *and expansion* of this program is a critical goal for me and, it is my understanding, for many of my colleagues on this Committee.

I also would like to underscore the importance of ensuring that health insurance expansion efforts result in meaningful coverage. Such coverage should include access to important and cost effective services such as primary and preventative care as well as coverage for services—just as critical, but often overlooked, such as oral health and mental health services.

Senator Maria Cantwell
Senate Finance Committee Hearing Statement
Charting a Course for Health Care Reform: Moving Toward Universal Coverage
March 14, 2007

Thank you, Mr. Chairman. I appreciate your leadership in health reform, and thank the witnesses for coming to share their perspectives with us today.

Let me begin by saying what we all know to be true: Health care reform is not easy. Solutions are difficult to negotiate, and consensus is hard to come by.

Despite these challenges, we all understand the magnitude of the problem we are facing. I hear about it from my constituents in Washington state, and I am sure my colleagues hear the same from theirs.

I hear from hard-working individuals whose employer health premiums are rising to unmanageable levels. I hear from parents who worry about getting their kids the care they need, and I hear from seniors who are forced to choose between paying for food and medications.

Above all, I hear from those who are tired of the status quo.

About 14 percent of those in my state are uninsured, including almost 100,000 children.

Nationally, there are over 46 million uninsured people—9 million are children.

In addition, those with insurance are dealing with skyrocketing health costs. Premiums for family coverage have increased by 87 percent since 2000, and overall premium costs are outpacing wage gains by 3.8 percent.

Now is the time for action.

In the absence of federal leadership, states are taking it upon themselves to reduce the number of uninsured. Just yesterday, the governor of my state signed legislation into law that will provide health coverage for an estimated 38,000 children.

This new law is part of a long tradition of health reform in Washington state. In 1987, Washington launched the Basic Health Program, the first of its kind in the nation to provide health insurance coverage for low-income state residents not covered by Medicaid. In 1994, Washington was again one of the first states to expand health coverage, this time by expanding Medicaid eligibility for children at up to 200 percent of the federal poverty level.

I'm encouraged by efforts in Washington, Massachusetts, and other states to address the growing ranks of the uninsured. As federal legislators, we also have a responsibility to ensure everyone has access to quality health care.

We can improve care coordination by investing in health information technology. We can introduce transparency into the market and encourage practices that benefit the consumer. And we can strengthen prevention efforts that result in better health outcomes for patients and lower costs for providers.

I'm looking forward to discussing these and other items as this debate moves forward. Health care is not an easy issue to tackle, but I'm confident we can find the solutions that will bring about meaningful reform.

Statement of Richard G. Frank, Vice Chair
Citizens' Health Care Working Group

Hearing on Health Care Reform and Health Insurance Coverage

March 14, 2007

United States Senate Committee on Finance

Statement of Patricia A. Maryland, Chair
Citizens' Health Care Working Group

United States Senate Committee on Finance

March 14, 2007

Mr. Chairman and members of the Committee, thank you for the opportunity to share with you the experience of the Citizens' Health Care Working Group, which originated in bipartisan legislation sponsored by Senators Wyden and Hatch, and was created to engage the public in a nationwide discussion about how to improve health care in the United States. The fourteen citizen members of the Working Group represented an informed cross-section of the American people, in addition to the Secretary of Health and Human Services. It was my privilege to serve as the Vice Chair of the Working Group. My statement reports on what we learned and offers the Working Group's recommendations.

OVERVIEW

The unpleasant reality is that the health care system that captures vast amounts of America's resources, employs many of its most talented citizens, and promises to both promote health as well as relieve the burdens of illness is failing far too many of us.

On last report, the number of uninsured Americans has grown to 47 million, rising by more than one million a year. Tens of millions more are underinsured and at immediate risk of financial ruin if they are seriously ill or injured. Individuals, families, employers, and every level of government are feeling the financial pressure of rising health care costs. More often than not, people do not receive the best care that science has to offer. Many are bewildered by the complexity of health care and insurance coverage. As one citizen voiced to us, you cannot "*navigate the health care system without luck, a relationship, money and perseverance.*" The need for change is clear, but transforming health care so that it works for all Americans is a daunting prospect. It will involve difficult decisions about how health care is organized, delivered, and financed. Years of stalemate on health reform prompted a bipartisan call to go back to the American people, to explore their values and aspirations for the health care system, and to provide the energy needed to sustain real health reform.

The Citizens' Health Care Working Group was established by Congress to "*engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.*"

What we heard was that many Americans believe that public policy designed to address the growing crisis in health care cannot succeed unless all Americans are able to get the health care they need, when they need it.

PUBLIC DIALOGUE

Following six regional hearings held in 2005 with experts, stakeholders, scholars, and public officials, the Working Group issued *The Health Report to the American People*, a report intended to facilitate a national dialogue on health care reform. In addition, the Working Group has made the presentations from its hearings available to the public via the Internet, at www.CitizensHealthCare.gov.

The Working Group then initiated an extraordinary effort to reach out to diverse communities representing a full spectrum of the American public. This began with a review of over 100 public opinion polls taken between 1991 and 2006. It also included a review and analysis of policy and research literature, surveys, and special analyses of health data; live one-on-one conversations and community meetings; expert research; and mass communications through the Internet and press. Over nearly eighteen months, the Working Group directly engaged thousands of Americans, including:

- About 6,650 people attending 84 community meetings across the nation as well as meetings organized by individual Working Group Members and other organizations by the end of May, 2006, and input from over 700 people attending 14 meetings after the Interim Recommendations were published on June 2nd.
- Over 14,000 responses to the Working Group Internet poll; and another 6,000 sets of responses to open-ended questions about health care in America
- Over 500 descriptions of experiences with the health care system submitted via the Internet or on paper, and about 400 e-mail letters, handwritten notes, letters, essays, and copies of reports that people sent to the Working Group.
- About 7,300 individual e-mail and written comments on the Working Group's Interim Recommendations

The Working Group recognized that many people attending the meetings or providing input in writing are likely to be especially interested in health care. Because of this, the Working Group held a variety of special topic meetings, some in collaboration with partner organizations, and also worked with a range of organizations to encourage their members to complete the Working Group poll or to write in comments. Among these were meetings organized by, or with the help of, groups including local Chambers of Commerce, The National Association of Realtors, The Consolidated Tribal Health Council, a consortium of Big Ten Universities, local chapters of the League of Women Voters, professional nursing associations, organizations serving homeless persons, unemployed persons, people with disabilities, and elderly persons. Several national corporations and national labor unions encouraged members to attend meetings and provide input via the Internet, and both the Catholic Health Association and the United Church of Christ were particularly active in eliciting input to the Working Group.

The remarkable consistency of findings from national polls, community meetings, poll data from the Working Group Internet site, and the University Town Hall Survey give us confidence that we heard the views of a broad segment of the American people. We do not claim that we know, with complete certainty, the health care values and preferences of all Americans. Rather, we based our deliberations on a careful assessment of input from as many sources as feasible, including tens of thousands of people from all across the United States, taking into account the gaps or biases that may be reflected in individual sources of data.

What We Heard

In every venue, we heard from Americans who are deeply concerned about access to health care, and the rising costs of care and insurance. While Americans recognize that health care costs are a major problem for businesses, industry, and government as well as families, many believe that the huge sums now being spent on health care should be enough to ensure access to quality care for everyone, if these resources were allocated more sensibly. At the same time, people consistently emphasized the importance of shared responsibility and fairness – a clear willingness to pay a fair share, to try to do a better job of taking care of themselves, and to accept limits on coverage if based on good medical evidence. Many believe that health coverage should be comprehensive enough to ensure people can get the care they need, when they need it, without having to negotiate or hurdle complicated administrative barriers. They told us they want health care to be available where people need it, in their communities. Finally, people told us that they want interactions with health providers to be based on mutual trust and respect.

The Working Group heard a variety of views regarding how a national system of health care should be organized -- from support for an entirely federal system with no private health insurance at all, to state-based single payer systems, to private sector participation in a system with established standards for benefits, coverage, and cost with minimum government involvement in day-to-day operations, to entirely free-market approaches. There was, however, overwhelming support for a plan that covered all Americans. In addition, there was considerable discussion at many meetings about interim reforms that could increase coverage until comprehensive changes could be made.

Opinions about incremental reforms were sharply divided and varied considerably from community to community. The overriding message, however, was consistent across every venue we explored:

> ***Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to ensure access to appropriate, high-quality care without endangering individual or family financial security.***

People also conveyed a sense of urgency and wanted changes to start immediately.

Values and Principles

In developing recommendations, the Citizens' Health Care Working Group believes that reform of the health care system should be guided by principles that reflect the values of the American people:

- Health and health care are fundamental to the well-being and security of the American people.
- Health care is a shared social responsibility. This is defined as, on the one hand, the nation or community's responsibility for the health and security of its people, and on the other hand, the individual's responsibility to be a good steward of health care resources.
- All Americans should have access to a set of core health care services across the continuum of care that includes wellness and preventive services. This defined set of benefits should be guaranteed for all, across their lifespan, in a simple and seamless manner. These benefits should be portable and independent of health status, working status, age, income or other categorical factors that might otherwise affect health-insurance status.
- Health care spending needs to be considered in the context of other societal needs and responsibilities. Because resources for health care spending are not unlimited, the efficient use of public and private resources is critical.

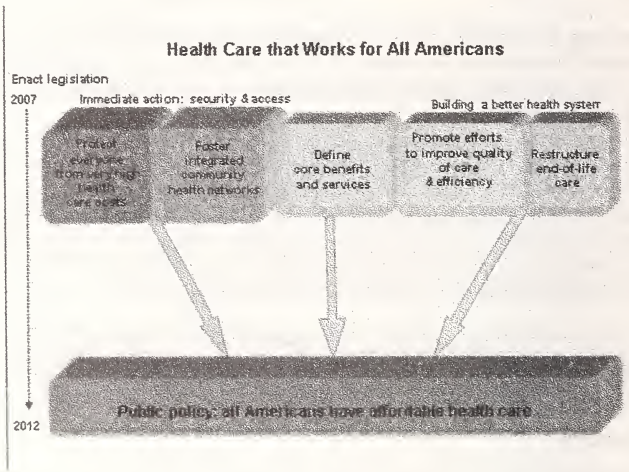
Recommendations

Based on these values and principles, the Working Group proposes six recommendations–organized into three sets–to accomplish its central goal, stated in Recommendation 1.

1. Establish public policy that all Americans have affordable health care. A clear majority of participants in community meetings, as well as those who responded to a numerous national polls conducted over the past few years, are in favor of universal coverage. However, "universal coverage" means different things to different people. The values and preferences being expressed did not lead the Working Group to conclude that there was only one particular model for ensuring that all Americans have access to high quality health care. Several approaches need to be analyzed and debated.

Also clear is that all Americans want a health care system that is easy to navigate. They want to have stable coverage when circumstances change, such as when they change jobs, get married, or move to a different state. People want decisions about what is and what is not covered to be made in a participatory process that is transparent and accountable. It should draw on best practices, resulting in a clearly defined set of benefits guaranteed for all Americans. The overwhelming majority of Americans that the

Working Group heard from also want health care system change to begin now. The Working Group is therefore recommending immediate action with a target of 2012 for ensuring a core set of benefits and services for all Americans. A five-year transition is recommended, with the immediate first step being to address serious threats to health security: very high costs, and gaps in access to basic health care, preventive services, and health education at the community level.


Health Care that Works for All Americans
Enact legislation
2007
Immediate action: security & access
Building a better health system
Protect everyone from ensuring health care costs
Foster integrated community health networks
Define core benefits and services
Promote efforts to improve quality of care & efficiency
Restructure end-of-life care
Public policy: all Americans have affordable health care
2012

STEP ONE: Immediate action to improve security and access

2. Guarantee financial protection against very high health care costs. The program the Working Group is recommending would provide some level of immediate protection for everyone, and also has the potential to stabilize existing employer-based health insurance markets and expand the private individual and small group health insurance markets to more Americans. More important, it will establish the principle of universal coverage and provide the foundation for providing core benefits and services to all Americans as called for in Recommendation 1. This program could be structured in a number of ways, using market-based or public social insurance models.

3. Foster innovative integrated community health networks. We heard concerns across the country related to a lack of primary-care providers; the inability to access specialty care; and, difficulties in navigating a complicated system, especially for those with chronic conditions. Citizens in multiple locations spoke highly of the continuity of care and easy access to needed services they receive from comprehensive delivery systems. The goal is to help communities build programs of a similar nature, where

health care providers at the local level are brought together to ensure that more people can have access to primary, mental health, and dental health care, and improve the effectiveness and efficiency of health care delivery. This step would immediately provide low income Americans with access to a comprehensive set of health care services that would move the delivery system towards one that is more likely to efficiently supply quality care.

STEP TWO: Define Core Benefits and Services for All Americans

4. Defining the core benefits and services that will be assured to all Americans. The conversations in each and every community meeting demonstrated how difficult the task of defining basic health care coverage will be for policymakers. Many people expressed concerns about what they view as the arbitrary exclusion of benefits or services from coverage. As was the case in many deliberations, the public was aware of the political challenges involved in making such decisions and the virtues of independent commissions in helping policymakers with such choices.

To define core benefits and services for all Americans, the best methods must be applied in a transparent process. Consumer participation is critical to ensuring public trust in the process and essential for ensuring that personal values and preferences are taken into consideration in coverage decisions. The group making decisions should be established as a public/private entity to insulate it from both political and financial influence. The group should be an ongoing entity with stable funding, to guarantee its independence and to assure that the benefits continue to reflect advances in medical research and practice. Evidence used to make decisions about coverage can contribute to improvements in the overall efficiency of health care delivery and help patients and providers make informed decisions. Identifying core benefits can help make all health care more effective and efficient, helping to control health care costs overall.

STEP THREE: Build a Better Health System

5. Continue to Promote efforts to improve quality of care and efficiency. A message that resonated throughout the public discourse centered on how America could do a better job with its $2 trillion a year spending on health by achieving greater efficiency and improving quality.

Concerted efforts in some integrated health care systems have demonstrated how care can be improved and waste dramatically reduced. Continuous improvement methods have reduced costs by managing chronic conditions, providing tools for informed decision-making, reducing preventable care-associated patient injuries, and designing coordinated systems of care delivery that reduce hassle and the need to redo tests and procedures. However, continuous improvement efforts rest on fundamental changes in medical practice and culture – a difficult, long-term, proposition. Widespread improvement will require a much better understanding of how to "do it better" (investment in health care delivery research), restructured training programs, significant

organizational restructuring, and investment in aligned health information technologies and systems.

The federal government is a dominant purchaser of health care. It also plays a significant role in the research and evaluation of the delivery of health care services. It is well positioned to provide leadership in these areas. A variety of federal programs could be used for development, demonstration, and dissemination. Federal health programs run the full range of design possibilities, making them particularly useful for new ideas.

6. End-of-life care should be fundamentally restructured so that people of all ages have increased access to these services in the environment they choose. Many end-of-life issues are intertwined with effectiveness, quality of care, clinical decision-making, and patient education addressed in Recommendation 5. The concerned and thoughtful attention to end-of-life issues that emerged through its public dialogue made clear to the Working Group that change is needed.

Currently, the policy development is hampered by a lack of useful information about patients' needs and use of services. The development and use of standardized instruments for collecting demographic, epidemiological, and clinical information, careful evaluation of emerging care models, and the dissemination of best practices are all needed to improve care for the dying. The Working Group acknowledges that end-of-life issues are often difficult, painful, and complicated and thus not conducive to quick or easy fixes. This recommendation seeks to better define, communicate, and make available at individual, family, community, and societal levels the support needed and wanted in one's last days. Public and private payers should integrate evidence-based science, expert consensus, and linguistically appropriate and culturally sensitive end-of-life care models so that health services and community-based care can better handle the clinical realities and actual needs of patients of any age and their families.

Financing

No plan to address the serious shortcomings in today's health care system would be complete without considering how to pay for it. After considering the discussions at community meetings, citizens' comments received in its web-based polls, public opinion expressed in national polls, along with proposals put forth by government agencies, think tanks, and scholars, the Working Group arrived at three guiding principles to financing new initiatives:

- The financing methods should be fair. Financing methods should not have the effect of creating a disproportionate increase in the financial burden on the sick; responsibility for financing of health care should be related to a household's ability to pay; and all segments of society should contribute to paying for health care.
- The financing methods should increase incentives for economic efficiency in the health sector and the larger economy.
- The methods should be able to realize sufficient funds to pay for the recommended actions.

The Working Group believes that a number of the recommendations made in this report force a difficult choice of finding sources to pay for these actions or contributing to sizable budget deficits. Some of its proposed actions would result in opportunities to reallocate existing funds spent by state and federal governments. These would include payments by Medicaid under disproportionate share hospital (DSH) provisions, high-cost risk pools, and uncompensated care payment programs.

Some of the actions proposed in this report may also yield savings to the health care system in the long term, but based on the evidence and conversations with experts, the Working Group has concluded it is unlikely that health system improvements will yield sufficient savings over the next few years to pay for all of the reforms recommended in this document. In addition to reallocating existing funds and harnessing savings, a third source of financing would stem from making changes in existing government subsidy programs that are at once inefficient and unfair. Based on recent reviews of federal subsidy programs by the Congressional Budget Office, the President's Commission on Tax Reform and independent scholars from across the political spectrum, the Working Group believes that significant funds would be available by altering such public subsidy programs in a way that improves both economic efficiency and fairness. Finally, if these sources were not sufficient to address the funding requirements of the six recommendations presented, new revenues would have to be considered. The Working Group strongly believes that in order to gain the confidence of the American public, it is critical that funds obtained from reallocations, savings, changes in subsidy arrangements, or new revenues be specifically dedicated to health care coverage.

Based on a review of national polls, the Working Group's own Internet polls and discussions at community meetings, it is clear that a large segment of the American people believe there are sufficient funds associated with American health care to pay for health care that works for all Americans. As a result, there is a strong sense in the public that reallocation of existing public funds, changes in subsidy programs, and increased efficiency should take priority in funding the recommended actions. Yet when posed questions about the possible need for new revenues, we found that the majority of people were willing to pay some more to ensure that all Americans are covered. This has also been found consistently in national polls.

Conclusion

Adopting these strategies simultaneously enables the American health care delivery and financing systems to take several important steps toward universality. It sets in motion a plan that responds to overwhelming public support for a new dynamic in American health care where everyone is protected, not just select portions of the population.

If the United States Congress decides that fundamental change in health care is either too disruptive to the economy, too complex, or too controversial and defers further action at this time, the Working Group fears that the cost of this inaction to American

families goes beyond dollars and cents. The problem of medical providers charging the insured more to cover costs of the uninsured will become even more prevalent. Public budgets will continue to feel the pressure of both the growing numbers of uninsured people and of the aging population, as long-term care costs consume an even greater share of Medicaid funds. Additionally, uncompensated care costs—now estimated to be more than $40 billion annually—will continue to rise, placing huge burdens on hospital providers and even forcing many safety net providers to close.

Furthermore, health care premiums will continue to rise. These increases will make it more difficult for many businesses to continue coverage for their workers and retirees; they will continue paring down coverage and shifting costs to employees. Individuals and families will find it more difficult to purchase coverage from their employers or the individual market and may not be eligible for public programs. States will continue to explore ways to provide coverage to their residents, but finding the revenue to pay for these programs could threaten budgets or lead states to raise revenues in ways that drive out businesses. The uninsured will continue to receive less care and less timely care, to sustain more financial risk and to live, on average, shorter lives. The ramifications of the changes above will reach to every facet of American society, fundamentally altering the economy from what it is today.

This predictable tragedy must be avoided. Doing nothing to address a failing health care system will surely cost us more tomorrow than will acting today. The Citizens' Health Care Working Group urges timely action on these recommendations for making health care work for all Americans.

Response to Questions from United States Senate Committee on Finance re: Public Hearing on "Charting a Course for Health Care Reform: Moving Towards Universal Coverage"

Richard G. Frank; Vice Chair, Citizens' Health Care Working Group and Professor, Harvard University

Questions from Senator Baucus

1. What is biggest roadblock to reform?

The information obtained from the Citizens' Working Group's efforts to create a dialogue with everyday Americans, along with a review of past efforts, offers some lessons about road blocks to reform. The American public sees health care affordability and the large number of fellow citizens that are uninsured as a very important problem. This was revealed in every meeting, every poll and every conversation the working group conducted. The failure to engage the American public in support of reform has been a major road block. This means offering proposals that a) directly address the most important problems (affordability and coverage); b) proposing solutions that can be clearly seen as solutions to the important problem; and c) offering a sense that the burden and benefits required to reform health care are fairly shared.

We found that there are misperceptions by the public about the role of government in health care. It is not well understood that between 40% and 50% of spending on health care directly involves the government. The experience since the defeat of Clinton health reform suggests that the health care marketplace left alone is unlikely to be able to solve the affordability and coverage problem. Thus it seems that the government must play some role in orchestrating a solution even if in the end it relies on the private market to carry out the plan. This must be explained to the public in order to generate the type of support that might result in a bipartisan agreement on reform.

2. Are the American people willing to make sacrifices to have universal coverage?

In our dialogue with the American people and our comprehensive review of public opinion polls we identified several important themes that pertain to the willingness of the public to make sacrifices. First, and most important, we were impressed by the recognition that universal coverage will likely require that more money be spent on health care, at least in the near term. In both public opinion polls and in responses to questions at our community meeting, the majority of Americans are willing to pay more to ensure that all Americans have access to affordable, high quality health care. The Working Group poll indicated that 12% would be willing to pay $1,000 or more and 17% would be willing to pay an additional $300 to $999. Another 19% said they did not know and only 13% said they would not be willing to pay anything extra. . It is important to note that the additional amounts most people report that they are willing to pay may not be sufficient to cover the estimated costs of universal coverage ($70-100 billion per year). We also heard a great deal of concern by the public about excessive spending,

inefficient delivery, and poor allocation of funds. One area that people identified as a possible area for significant savings from changing the nature of care was end-of-life care (see pages 48-50 of our Dialogue with the American People). This perception leads people to be suspicious about demand for new payments that are not linked to efforts to address the inefficient practices in health care delivery. Finally, in nearly all meetings held by the working group participants expressed a general recognition that everyone must participate in any health care coverage plan. (see pages 30-31 of the Dialogue...).

3. Are American businesses prepared to make sacrifices to have universal coverage?

I am not well positioned to answer this question.

4. What should we be mindful of in changing the status quo? Can each of you avoid pitfalls that we must avoid? What lessons can we learn from past unsuccessful health reform efforts?

I will respond to this question as a student of health policy rather than as Vice Chair of the Citizens' Health Care Working Group. I believe that the history of health reform efforts suggest that it is important to be mindful of several key factors and facts. First, the health sector involves about one-sixth of the economy. The more one tries to do the larger are the numbers of winners and losers produced. Therefore the more features of health care delivery one tries to reform, the tougher will be the opposition. Second, the greatest mistake in developing health reform plans is the suggestion that covering the uninsured can be done without any new financing. There is no doubt a great deal of inefficiency, waste and fraud in our health care system. Yet it is extraordinarily difficult to identify it precisely and then capture it to finance health care for people who are uninsured. Third, there are a host of inefficient and unfair tax subsidies that exist in our health care system that can be put to work in the service of covering the uninsured and attenuating cost growth.

5. Where do the American people want to start? What is most urgent in their minds?

The most important concern of Americans relates to the affordability of needed health care. People are afraid that in the event of a serious medical condition they would either not be able to afford appropriate care or that it will impose a catastrophic financial burden on them and their families. Closely related is the sense that insurance coverage is increasingly costly and potentially unaffordable which then exposes people to the full financial risk of illness. The Working Group encountered this sentiment regardless of the source of data examined and across all the meetings we held. A second frequent concern was that the health care system is so complex and opaque that it is difficult for people to successfully navigate it and get the right care at the right time. The implication of these observations is that Americans place a high priority on being protected from the potentially crushing costs of treating disease or sustaining an injury. Establishing the principle of universality is an important first step. In addition, when asked about the primary role of insurance the majority in most places cited protection against high

medical costs. It is for this reason that the Working Group recommended that the Congress act immediately to protect all Americans from very high health care costs.

6. Given the public comment in opposition to changing the Health Centers Law, why did the Citizens Working Group consider revising or eliminating the recommendation? (The answer here also pertains to **Senator Hatch's** question).

The Working Group recommendation to foster the development of innovative integrated community health networks addresses serious concerns we heard across the country related to a lack of primary care providers; the inability to access specialty care; and, difficulties in navigating a complicated health care system, especially for those with chronic conditions. Within our deliberations, this recommendation generated a very animated discussion.

This recommendation is geared to fixing the health care delivery system at the community level. We heard many stories of the difficulties people face getting the care they need because the system is complex and difficult to navigate when one has insurance and these difficulties are exacerbated when one does not. Aspects of this recommendation are directed at the health care safety net, that loose coalition of providers whose composition varies from one place to another but whose members share the mission of assuring some level of care for those most in need. These safety net providers face difficult challenges: fragmented and often inadequate funding; patients who may not always be able to follow medical regimens because of the circumstances of their lives; and difficulties in making referrals, to name just a few. We want to encourage government and the private sector, starting at the community level, to begin using a systems approach in considering these providers. We hope this leads to enhancements like the implementation of electronic health records and the use of evidence-based interventions in managing chronic illness. We hope to encourage this same systems approach at the state and federal levels of government as well, but it is important to emphasize that these networks are not government entities, but rather coalitions of private and public entities.

We see this systems approach to health care as an approach that could benefit all in the community. Health care providers in a community network would emphasize:

- A medical home for all participants, with access to primary care, mental health services and dental care
- An approach based on wellness, with appropriate preventive services
- Referrals as needed with consistent follow-up
- Removal of bureaucratic and other barriers to care. For example, office hours would be available at convenient times

A community-centered approach will be good for the health of individuals but will also improve the well being of communities.

We received many comments from individual community health centers and their associations asking us to remove from our recommendations the proposal to "expand and modify the Federally Qualified Health Center concept" to allow additional providers to qualify for some of the benefits now limited to community health centers. Specifically we received 28 comments from community health centers objecting to expanding and modifying the FQHC concept.

We received 7,500 comments from individuals about the interim recommendations. We also received 1000 comments that were routed through the Catholic Health Association and 80 letters routed through the American Federation of State, County and Municipal Employees (see Appendix G of our Report). Over 70% of individuals commenting on the "Community Networks" recommendations on the Internet were supportive of the findings. Of those that disagreed (less than 30%) one-third cited concerns about creation of bureaucracy; and one-fifth wanted a more comprehensive universal coverage approach to be immediate. Given these data we did not perceive there to be an overwhelming majority of Americans opposing our recommendation. .

It is most important to emphasize how impressed the Working Group members were with work done by FQHCs. The Working Group members are grateful for the valuable contributions the community health center program has made in providing care to low-income people over its 40-year history and the central role community governance plays in the program. In no way does this recommendation seek to undercut either the program or its structure. The Working Group notes, however, that the organization of health services at the local level varies from community to community. Other successful models of care delivery can be found in many localities. To the extent that these safety net providers are doing similar work for groups of people much like those served by community health centers, they should be encouraged through federal incentives.

We hope that this clarifies both our process and the intent of our recommendations.

Question from Senator Kerry

Do you think a revenue increase is an appropriate way to finance expanded health care coverage? Do you have other suggestions on how to finance expanded coverage?

The Citizens' Health Care Working group raised these questions throughout the country at public meetings on health care. Our review of polls along with citizen responses to questions on financing led the working group to several findings and ideas about financing expanded coverage. Our reviews of polls and responses at our meetings show that Americans are willing to pay more to ensure health care coverage for all Americans. Yet the amounts they are willing to pay will not typically cover the predicted costs of expanded coverage (see response to Senator Baucus' question #2).

In reviewing suggestions from the public along with those from experts in health policy other directions emerged for financing expanded coverage. These included expansion of

"sin" taxes, especially those on alcohol,and restructuring federal tax subsidies for the purchase of health insurance coverage.

Questions from Senator Kyl

1. Do you agree that Congress should examine the tax treatment of health care, particularly the more favorable tax treatment for an individual who receives employer sponsored health coverage compared with an individual purchasing health coverage on his own?

Restructuring the tax treatment of health insurance represents an opportunity to improve efficiency and fairness in the financing of health coverage in this country. The Citizens' Health Care Working Group reviewed a variety of proposals for altering the tax treatment of health insurance, including ideas from the President's Commission on Tax Reform, the work of independent scholars and analysis by the Congressional Budget Office. The Working Group identified the restructuring of the tax treatment of health insurance as one means of controlling costs, financing coverage expansions and correcting existing inequities.

2. During the Working Group's community meetings and its surveys, what did a majority of respondents identify as the most important reason for health insurance? Did they support access to coverage that protects against expensive, catastrophic events? Or did they prefer access to health care coverage that pays for everyday medical expenses?

The majority of respondents at most of our meeting and to our polls indicated that the primary purpose of insurance was to protect against high medical expenses and catastrophic costs of illness (see for example appendix page C-1 of our Report). One meeting participant captured the larger sentiment by stating, "...homes and savings can be lost in the blink of an eye". It is based on these results that the working groups offered its Recommendation # 2 that call for immediate action to Guarantee Financial Protection Against Very High Health Care Costs.

Questions from Senator Cantwell

1. What are your suggestions for tackling the wide regional variations in health care spending?

The large variation in spending that has been documented by the researchers at Dartmouth represents an important phenomenon in health care delivery that is not well understood. Dr. Wennberg testified at our hearing that was held in Salt Lake City, Utah early in the Working Group's deliberations. There are a variety of conflicting views and interpretations of what produces the variation and what should be done about it, even within the Dartmouth group (see the recent research published by Chandra and Staiger, Journal of Political Economy). What one should do depends on what one believes is the cause of the variation. My own view is that it probably represents a mix of cultural and

preference differences, specialization in medical care and differential efficiency. Given this view, an initial first step would be to focus on creating incentives for improvement in the efficiency of health care delivery and to encourage medical care to be organized and delivered in ways that have been shown to reflect best practices. The Citizens' Health Care Working Group suggested that one place to start is for the federal government to consistently use its role as a major purchaser (in Medicare, FEHBP etc) to advance improvements in the delivery system and to create incentives for efficiency. In deciding what practices to encourage there are important lessons to be learned from observing local health care delivery systems. In our travels the Working Group visited model programs across the country. Programs in Utah, Mississippi, Michigan, Washington and elsewhere impressed us.

2. What is the one thing we could do this year, in addition to reauthorizing SCHIP that would make a measurable difference?

The Citizens Health Care Working Group offered two recommendations that call for immediate action that we believe would make a big difference and would put the nation on a path towards an improved health care delivery system. The recommendations are:

a) To Guarantee Financial Protection Against Very High Health Care Costs

This would be important because it would provide immediate protection against a set of threats that jeopardize the economic security of millions of American households and small businesses. It also has the added benefit of establishing the principle of universal coverage. Finally, by our assessment, it would be affordable in acknowledgement of existing federal budgetary conditions.

b) To Foster Innovative Integrated Community Health Networks

Using our understanding of best practices to expand the community health infrastructure that would provide efficient high quality care to families of all income levels across the nation is critically important. This recommendation (explained fully on pages 15-17 of our report) builds on what has been learned from providers like Group Health Cooperative, Intermountain Health, the nation's most successful FQHCs and other local health care delivery systems. This initiative responds to directives from citizens to "fix the delivery system."

3. Can you talk about how states are leveraging existing programs to expand coverage and the importance of building what we already have in place to achieve broader coverage?

Certainly, the experience in Massachusetts illustrates the importance on using key institutions to craft a solution to the health care coverage problem. Massachusetts leveraged its existing Medicaid waiver, its uncompensated care pool and the structure of safety net health plans and providers to create a political and economic environment to expand coverage.

The Citizens' Health Care Working Group came to understand how important local health care institutions are to everyday Americans. Community clinics, hospital systems and public programs are generally trusted parts of the community. There was great support around the country for developing solutions to health care affordability and coverage problems by using these trusted institutions as building blocks for a better system.

United States Senate
Committee on Finance

Sen. Chuck Grassley · Iowa
Ranking Member

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Opening Statement of Senator Chuck Grassley
Senate Finance Committee Hearing
"Charting a Course for Health Reform: Moving Toward Universal Coverage"
Wednesday, March 14, 2007

Thank you, Chairman Baucus, for holding this hearing today. The health care system we have in place today is not sustainable, plain and simple. Last year health care spending exceeded $2 trillion, more than 16 percent of the GDP. Costs continue to climb and there is no expectation they will stop. By 2015, health care spending is expected to reach $4 trillion, about 20 percent of the GDP. So everyone can relate to what those numbers mean, I can tell you that, on average, every American spent nearly $7,000 on health care last year. In 2015, that number will climb over $12,000 per person.

The financial burdens of health care costs are being felt by American business. Employers are finding it increasingly challenging to compete in the international market against foreign companies that are not required to directly provide health coverage for their employees. For example, ATT spends $5 billion annually on health care costs for 1.2 million employees. The United States Chamber of Commerce reported that medical expenses accounted for most of the rising employee benefit payroll costs paid by employers. As a consequence, in 2005 employer-sponsored health insurance now only covers 61 percent of the non-elderly population – a drop of more than 8 percent since 2000.

Most working Americans do have health insurance coverage. But the Census Bureau estimates that over 46 million Americans are without health insurance and the vast majority of those people are employed. Sixty-nine percent of the uninsured are in families with at least one full-time worker and another 11 percent are in families with at least one part-time worker.

There are many reasons why Americans are uninsured. Since the vast majority of the uninsured, 65 percent, are in families with incomes of less than 200% of the federal poverty, cost is certainly a factor. Clearly, the cost of insurance has forced many Americans to put their health at risk by going without insurance. But, the adverse effects of the uninsured are not limited to the uninsured themselves. There is also great cost to the community – to me, you, taxpayers, consumers, providers, and so on. The Institute of Medicine estimates the uninsured population costs society somewhere between $65 billion and $135 billion.

Mr. Chairman, this situation is untenable. But I am heartened by the fact that we are seeing more new policy ideas as more people realize the seriousness of the situation. In his budget, the President has provided us an outline to consider in looking for ways to cover the uninsured. It is not perfect, but it is a place for us to start. The President gets us started on using the tax code to create incentives, along with the public-private partnership of his Affordable Choices Initiative. Real solutions for the uninsured will involve proposals that use many tools, not just a one-size fits all approach.

I support ideas that incentivize greater private coverage. Covering everyone with government-run health care is not the right direction for America. I also think my friend from Oregon, Senator Wyden, has made a very serious proposal with his Healthy Americans Act. He has written a bill that has something for almost everyone of every political flavor to object to, so he must be close to the answer. But with all seriousness, Senator Wyden is very passionate about this subject and I think his tireless efforts to get people to pay attention contribute greatly to the debate. Mr. Chairman, moving major legislation during a presidential election cycle is extraordinarily difficult but not impossible. Welfare reform and the Medicare drug benefit moved in a Presidential cycle. I'm encouraged by the fact that it seems there are more people in Congress talking about the issue than any time in the last decade. And so let me close with that. We have enough on the table that we have an opportunity to move beyond talk and to substantive action. Mr. Chairman, the number of uninsured is rising. Many employers do not provide coverage and those employers that do provide their employees coverage are finding it challenging to continue to provide health benefits for their employees while staying competitive. With every day that passes, we only make fixing the system more difficult. We are running out of time to make changes that will put us on a path toward a more stable health care community. Mr. Chairman, leadership must come from those on this committee to be the forces of change. I thank you for beginning the discussion on what needs to be done to ensure the availability of quality health care for all Americans.

Senate Finance Hearing
"Charting a Course for Health Care Reform: Moving Toward "Universal Coverage"
Statement for the Record
Senator John Kerry
March 14, 2007

Thank you, Mr. Chairman, for calling this important hearing. Universal health care coverage is the great unfinished business of half a century. 47 million uninsured Americans – including 11 million children under 21 – is a social injustice, a fundamental question of moral values, and an economic inefficiency that demands the attention of this Committee and this Congress.

I'm especially pleased to have three Bay Staters on today's panel. Stuart Altman is truly one of the founders of health care economics and has been a great find to me over the years, including helping us craft my 2004 campaign health proposal. Richard Frank from Harvard is a preeminent scholar in the field of mental health – an issue of which I have great personal and professional interest – and I want to thank him for his leadership in that area. And Dr. Jim Mongan – if we could just clone Jim, we'd be a lot closer to solving the health care crisis in this country. Thank you all for being here.

I think we should first recognize the true inevitability of the next great health reform debate. The American business community, which finances health coverage for the vast majority of the country, now sees the status quo as completely unsustainable – not only a major cost driver but also an economic disadvantage in the global marketplace. Further, the sheer budgetary size of Medicare and Medicaid will, for better or worse, make them an ongoing target as Congress begins to dig out of the fiscal irresponsibility of the past 6 years in Washington. Finally, and most importantly, the American people are once again demanding change – not just because they're tired of seeing millions of their neighbors suffer without insurance, but also because they recognize that the insured pay for the uninsured one way or another and there must a better way to do it than this.

But in the absence of executive leadership from Washington, many states have stepped up to help provide care to the uninsured. Massachusetts is furthest along in implementing a truly universal health care reform initiative – though we still have a long way to go.

That being said, we must recognize that the most effective and efficient approach to covering the uninsured needs to come from the federal level. At a minimum, this should come in the form of financial support at a scale that only we can provide and sustain over time. Beyond that, I believe the federal government has a role to play in ensuring standards and quality within our system, making it more fair and more efficient for all its participants.

I believe that one way for the federal government to begin laying the groundwork immediately is through federal reinsurance, an innovative, market-based approach to

stabilizing the employer market and reducing the growth of premium costs. A reinsurance mechanism like the one I proposed in 2004 would help our businesses get out from under the heavy financial burden of the expensive cases that hike up everyone's premiums.

We know that the high costs of treating the sickest patients are driving up the price tag for everyone else and taking a huge toll on our businesses. Just one percent of the population accounts for over 20% of health care expenses. The bottom half of all claims accounted for just three percent of all health care expenses.

The federal government ought to make a new deal with employers and health insurers. Here's the deal: we will reimburse a percentage of the highest cost cases if you include preventative care and health promotion benefits in your plan and implement practices proven to make care affordable. This means lower costs and lower premiums for both employers and employees. I intend to introduce reinsurance legislation this month.

One thing we must remember, however: If we want to get to truly universal health coverage, we're going to have to explore requirements. To make the risk-sharing and finances work, you need everyone in the pool. So I can support an individual requirement – like we've done in Massachusetts – <u>if and only if</u> it is backed up with provisions for affordability and insurance protections.

Hearing on Health Care Reform and Health Insurance Coverage
Senate Finance Committee
March 14, 2007
Testimony of
James J. Mongan, MD
President, Partners HealthCare

Mr. Chairman, members of the committee, I'm Dr. Jim Mongan, president of Partners HealthCare in Boston, a health care system founded by Massachusetts General Hospital and the Brigham and Women's Hospital. Relevant to this testimony, I also serve as chairman of the Commonwealth Fund's Commission on a High Performance Health System, and I am a member of the Kaiser Commission on Medicaid and the Uninsured.

If you would permit me a quick personal aside, I could not help but remember, as I entered this room this morning, the first time I entered this room 37 years ago this month, as a young physician, newly hired as a staffer for the Finance Committee, then under the leadership of Senator Russell Long and Senator Wallace Bennett. I was hired to work for both men on Medicare, Medicaid and national health insurance issues, and I stayed for seven years, over which time I developed tremendous respect for this committee and the responsibilities you face.

These health financing issues were difficult then, as they are now, and in fact sadly, with the passage of time, our situation with regard to health insurance has only gotten worse, not better. At our low point in 1976 we had 23 million uninsured or 11% of our population, today these numbers are, 47 million and 16%.

It is demonstrably long past time to act on this issue, and I applaud the committee for holding these hearings and initiating another, hopefully more fruitful effort to wrestle with this problem.

For many years now the Kaiser Commission on Medicaid and the Uninsured has issued reports and analyses on the issues surrounding lack of insurance. This past year the Commonwealth Commission released a framework statement and a scorecard rating the performance of our nation's health care system. The framework for a high performing health system included universal coverage as a key element. The scorecard documented our significant gaps in coverage. Both of these commissions are deeply interested in your committee's work and would be pleased to provide any assistance to your deliberations which you might seek.

In my testimony this morning I will address three key questions the nation should keep in mind as we begin what I hope will be more of a dialogue than a debate:

- First, why is health insurance important?
- Second, why has legislating on this issue been so difficult? and
- Finally, are there any general paths to success this time around?

First, why is health insurance important? It is important for reasons involving health, economics and simple justice. Although some believe the uninsured get care when they really need it, the definitive Institute of Medicine Report on the uninsured in 2004, by a committee I was privileged

to serve on, demonstrated that the uninsured are far less likely to have seen a physician in the past year, far more likely to postpone or go without care, and far less likely to receive preventive care. They are much more likely to be hospitalized for avoidable complications of asthma, diabetes, or hypertension. And uninsured working-age adults have a 25% greater risk of dying prematurely than insured adults after adjusting for demographic differences.

So health insurance is about health, not just about dollars. But it is also about economics, and the same IOM report in 2004 estimated that the annualized economic cost of the diminished health and shorter lifespans of Americans who lack insurance is between 65 and 130 billion dollars a year. These numbers include productivity losses and developmental losses due to poor health in children.

And finally expanding health insurance coverage is a matter of basic social justice – most families will never be free from fear of financial ruin without health insurance coverage.

So next, why has legislating on this issue been so difficult? It has been difficult for two reasons. First, expanding health insurance comes with a need for additional revenues – taxes in short. With regard to revenue, the Institute of Medicine subcommittee which I chaired in 2003 estimated that the price tag for services not received by the uninsured would range from 35 – 70 billion dollars a year, or about 3% – 5% of national health care spending – less than each year's annual increase in overall health care spending. Now the actual cost of any legislation would likely be higher,

anywhere from 70 - 100 billion dollars a year, because most bills would provide some subsidies to employers who offer coverage, state fiscal relief, or other support. In terms of our aggregate two trillion dollars of health spending, these numbers would not seem insurmountable. And in terms of federal taxation levels this revenue could be raised and still leave taxes at or below levels of the 1990's, tax levels which underpinned one of our most productive economic eras.

The second reason that legislating in this area is difficult is that we are quite divided as a nation ideologically, between those who favor a government approach and those who favor a market approach to health issues – especially cost issues. Neither side has seen much wisdom in the other's position and we have been stuck for 25 years on this point.

So now to my last question – are there any general paths towards success on this issue? My experience in Massachusetts this past year makes me somewhat optimistic that there may be. This is not because I think that the Massachusetts plan is the best or the only option, nor because I think states can ultimately deal with this issue on their own. Rather it is because as I watched and participated in the process in Massachusetts I saw legislators apply wisdom and commonsense in approaching the two difficulties, which I just described.

With respect to revenue, leaders in Massachusetts honestly faced up to the cost of expanding coverage, and addressed the revenue issue from a perspective of shared responsibility – <u>everybody</u> pays something. Federal funds, new state funds, preexistent insurer and provider taxes, new employer

contributions and mandated payments by individuals were all utilized. Is the resulting revenue package a perfect balance? Probably not. But we have made a good start, and the legislature can improve upon it in the future.

With regard to the stalemate between advocates of government regulation and advocates of market forces to control costs, Massachusetts leaders demonstrated some admirable intellectual humility. None of us has all the answers here. So the legislature crafted a package with pay for performance and other regulatory approaches, along side of increased price transparency and other market approaches. And they established a new administrative structure – The Health Insurance Connector, – which is both a regulatory agency and a market facilitator. Not knowing which camp was right our legislature tried to include the best thoughts from all sides.

So the path to success in Massachusetts, in my view, consisted of an honest appraisal of the problem, a shared commitment to solutions, a philosophy of sharing and fairness regarding revenue, and a sense of intellectual humility regarding philosophic approaches. I commend this formula to your attention as you begin your important and long overdue work on universal health care coverage.

Thank you for your attention.

Responses to Questions for the Record From James J. Mongan, M.D.
Finance Committee Hearing of March 14, 2007

Chairman Baucus' question: How can we get doctors, hospitals and other health care providers to be more proactive?

As I indicated in my testimony the path to working with all involved groups - business, labor, providers, insurers and others is to attempt to approach the issue with a sense of fairness and sharing in spreading the burden of financing expanded coverage. Coverage should not be financed by slashing reimbursement to providers arbitrarily but providers should be willing to contribute their fair share.

In addition we as providers have to do a better job of focusing our colleagues on the important health, social and economic factors that make universal coverage critical.

Senator Kerry's question: You mentioned your work as Chairman of the Commission on a High Performance Health System. Some might argue that insuring every American could actually be a drag on our health system. Can you describe how universal coverage is a key element of ensuring a high-performing system?

Some have argued that the key to gaining political consensus around the Massachusetts reform plan was the risk of losing hundreds of millions of dollars in federal waiver funding – that without this "gun to the head", it may not have been possible. Do you foresee a similar financial motivation emerging on the federal level, or do you believe that the debate would benefit from a self-imposed trigger (e.g. legislation that would require universal coverage by a certain date or face Congressional budgetary penalties)?

Our commission clearly indicates that universal coverage is a key element of a high performance system, as without it you cannot address other goals of access, quality, efficiency and equity.

As for the second question, I believe the major financial motivations that will increase pressure for passage will come when businesses realize that costs cannot be controlled without a broad coverage program in place.

Submitted by James J. Mongan, MD
March 29, 2007

Senator Salazar Statement
Senate Committee on Finance Hearing: "Charting a Course for Health Care Reform: Moving Toward Universal Coverage"
March 14, 2007

I want to thank Chairman Baucus and Ranking Member Grassley for holding this important hearing on health care reform. I look forward to working with the Members of this Committee to add my voice and efforts to meaningful, comprehensive health care reform that provides every American with affordable health care.

The United States is the richest, most prosperous nation in the world. Yet for all our advances, our health care system leaves an astounding 47 million Americans without health insurance. The uninsured come from every State of the Union, every community, every walk of life, and every race and ethnic group. But the most telling part about them is that they come from working families who struggle to put food on their tables and pay their bills. They live in constant fear of getting sick. When they get sick, they often go without medical care and get sicker.

Susan Molina, a Colorado resident, knows the worry, despair and health consequences of living without health insurance. Ms. Molina works full-time, yet cannot afford the high cost of health insurance for her family. Ms. Molina visited me last month before she testified before the House of Representatives Energy and Commerce Committee Hearing about the importance of fully funding the State Children's Health Insurance Program. She told me of the countless sleepless nights she endures worrying about how she will afford to take her children to the physician when they fall ill. For Ms. Molina and her family, the lack of access to affordable, quality health care is a constant worry.

The lack of health care has tragic, deadly consequences. Last month, a 12-year old boy, Deamonte Driver, who suffered from a toothache died after his tooth infection spread to his brain. His tragic death could have been prevented by a routine visit to the dentist. Our health care system failed him. The need for health care reform could not be more compelling.

Congress must act now to reform our system. Our health care crisis is not a Democratic or Republican problem. It is a national problem that we must solve together. I look forward to hearing the testimony of the witnesses and working with the members of this Committee to fix our broken health care system so that American families no longer suffer needless deaths and sleepless nights of worry and despair.

Testimony of John Sheils before the Senate Committee on Finance

March 12, 2007

Thank you for this opportunity to address the committee on rising health care costs and its impact on the rapidly growing number of Americans without health insurance. I am a Vice-president with The Lewin Group with 20 years experience in studying and analyzing proposals to reform health care and extend health insurance to the uninsured. We are committed to providing independent, objective and non-partisan analyses of policy proposals. The Lewin Group does not advocate for or against legislative proposals.

The number of uninsured in the US has been increasing by about one million people per year since 1990, despite state and federal efforts to expand coverage under Medicaid and the State Children's Health Insurance Program (SCHIP). During this same period, health care costs have grown at nearly three times the rate of general inflation as measured by the Consumer Price Index (CPI). The rapidly growing cost of health care has strained state and local budgets and driven up costs for employers and workers, resulting in a loss of coverage. Rising costs for employers have handicapped American industry in competing in international markets, reduced wage growth for workers and increased the ranks of the uninsured.

The United States spends more on health care than any other nation in the world. Average spending in the US is currently about $6,500 per person, which is nearly twice per-capita spending in Canada and most European countries. Yet the US lags behind many of these countries in life expectancy and health outcomes. Health care accounts for about 16 percent of national Gross Domestic Product (GDP), and is expected to reach 20 percent of GDP by 2015.

While it is widely recognized here and abroad that the US provides some of the most advanced health care in the world, the access our citizens have to this care is often very uneven. People with typical private employer health insurance have access to a broad range of medical

services, usually with only a minimal co-payment requirement. While the uninsured can receive emergency care from most hospitals, they have much reduced access to primary care and other non-emergent care services. This can include life-extending care for people with serious conditions such a radiation treatments for cancer patients. It also includes primary care that can prevent more serious health conditions.

Access to care for Medicaid participants also can be compromised in states where provider payment levels are substantially lower than the cost of providing these services. For example, payment levels for physician services can be as little as half of what is paid under Medicare, and hospital payments are often substantially less than the hospital's cost of providing these services. The use of managed care in many states has helped assure access for many Medicaid patients as a condition of contracting with the health plan. But there are still many providers who will not see Medicaid patients.

The result of these inequities in access is a de-facto rationing of care for the poor. Some nations explicitly ration care by restricting the acquisition of new technologies and limiting spending for physicians and other providers. In some countries this results in waiting lines for high cost procedures such as coronary surgery and dialysis. For the insured in the US, there is virtually no explicit rationing of care, and nearly immediate access to services. But we do ration care by under-serving the uninsured and enrolling the poor in public programs with inadequate provider payments.

Both the free care provided to the uninsured and the shortfalls in reimbursement for Medicaid services fuel cost growth for employer health plans through the cost-shift. When a provider provides services to an uninsured person who cannot pay, the hospital must find some way to cover these costs. They typically do this by increasing the amount charged to private payers for health services. Similarly, hospitals recover shortfalls in payment under public

programs through additional increases in private payer payments. Much of these "under compensated" costs are shifted to the privately insured, including employer health plans. (Although there is evidence that some of these costs are recovered by scaling back other hospital expenses.)

The cost-shift contributes to a cycle of cost growth that ultimately increases the number of uninsured. When costs are shifted to private employers, employer premiums increase. This can cause employers to discontinue coverage or pass the costs back to the worker by reducing covered benefits and increasing the employee contribution requirement (The available data indicates that the employee share typically increases in proportion to the overall cost increase to the plan). In many cases, the increase in the employee premium has caused some people to decline to enroll in the health plan offered at work because they cannot afford the employee contribution. There are about six million uninsured workers and their dependents that have declined the coverage offered to them through work, presumably because they can not afford the premium contribution. While there has been a small decline in the percentage of workers offered coverage through work, most of the loss of employer coverage in recent years is attributed to an increase in the percentage of workers who decline to participate in their employer's plan.

There is also a cost-shift across employers and industries attributed to coverage for working dependent spouses of covered workers. Nearly all insuring employers offer a family coverage option where the worker can cover their spouse and children as dependents. Employers cover about 20 million spouses who are actually working in other firms. Thus, the costs of covering workers in non-insuring firms are often shifted to insuring firms through coverage of working dependent spouses. This has led to a shift of worker health costs from low-coverage industries such as retail trade and services, to high coverage industries such as

manufacturing. Thus the lack of universal coverage in the US further increases health care costs for the very industries that compete most in international markets.

Rising health care costs for insuring firms also slow wage growth for workers. When employers experience an increase in health benefits costs they must either pay for the increase or reduce worker benefits, as many employers have done. However, increases in employer health spending limits the amounts that employers can provide in wage increases, resulting in slowed wage growth throughout the country.

Society incurs many other costs due to having such a large portion of the population without health insurance. It is widely reported by emergency care providers that they often provide treatment to uninsured patients for serious conditions that could have been avoided with proper preventive care. In particular, uninsured people with chronic conditions such as diabetes are often admitted for complications that could have been avoided with primary care and prescription drugs had they been insured. In fact, the Institute of Medicine (IOM) reports that about 18,000 uninsured people are admitted every year as a result of being uninsured. There are other economic costs due to a lack of coverage including more work loss days. Additional days of lost schooling for children could also diminish productivity for the next generation of workers.

The rising cost of health care is the chief cause of the increase in the proportion of Americans who are without coverage. As costs increase, fewer and fewer employers and individuals can afford to purchase health insurance, which places an added burden on state and local governments, safety-net providers and employers via the cost shift. The dilemma is finding a way to slow the growth in health care costs without forfeiting the advances in medical technology that are improving the quality of life for many Americans.

It is essential to recognize that the health care system provides new and improved services each year. For example, while there was little that could be done to treat AIDS sufferers in 1980, there are now treatments that can extend life indefinitely. Similarly, the advent of new procedures such as hip and knee replacements can dramatically improve the quality of life for recipients. We can not expect to benefit from continuing advances in medicine without paying for them. This is a world-wide problem. Many other nations are experiencing cost growth similar to that of the US.

One's health insurance card is the "key to the kingdom" of high quality American health care with all of its new medical advances. The fundamental problem with this is that advances in medicine increase the price of insurance to levels where fewer and fewer people can afford the "key" to the health care system. Appropriate health care is evolving into an ever expanding "luxury good" available to only those with the means to pay for it, leaving a growing sub-class of Americans without access to the best American medicine.

Thank You Mr. Chairman

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Senator Max Baucus, Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
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Dear Mr. Chairman:

Thank you for the opportunity to address the committee on the subject of health care and the uninsured. I was impressed with the quality of questions asked by members and the bipartisan way in which the issue is being addressed. There seems a general recognition of the need to address the problem of the uninsured and that there are no easy answers to the problem.

My responses to questions pertaining to me are presented below. The relevant questions are reproduced here in italics for your convenience. Please call at (703) 269-5610 if you have any questions.

Sincerely,

John Sheils
Senior Vice-President

Questions from Chairman Baucus

Question:

It seems clear that universal coverage is in everyone's best interest and has a lot of support. Yet I think anyone who follows health policy would agree that we've been here before – more than once – and yet the number of uninsured continues to grow. What is the biggest roadblock to reform? Is it the costs, the politics, the complexity of current system, some combination of these factors, or something else entirely?

Response:

I am afraid that what has been most lacking is the involvement of the uninsured themselves. There has never been a sizable march on Washington by the uninsured. If undocumented immigrants can stage a one-million person march on Chicago as they did last year, why haven't the uninsured been able to do so? A million person march of the uninsured on Washington could make quite a difference.

Our focus groups with the uninsured reveal that a significant portion of the uninsured could probably afford insurance but just don't think that the security of having coverage is worth the price. Young adults in particular anticipate little need for health care and often go without coverage even though coverage is often available at relatively lower rates for younger people. Many have other financial needs such as housing costs, an automobile to get to work, and various expenses for children. For many, going without coverage is a rational economic choice, particularly for families where no-one is currently ill.

These people are dubbed "free riders" by those that absorb the cost of uncompensated care. However, it is hard to find support for a $50 to $100 billion universal coverage bill when hospital uncompensated care costs for the uninsured are only about $19 billion (excludes "bad debt" which is largely attributed to unpaid co-payments for insured people). Unfortunately, there is little business case for covering the uninsured, even with reasonable assumptions on resulting improvements in worker productivity.

A less costly approach would be to increase funding for free clinics, target potentially high-cost chronically ill uninsured for preventive care, find a fair way to pay for uncompensated care and at least freeze the cost-shift for Medicaid underpayments. But this falls far short of the egalitarian ideal that all Americans should have equal access to the best of American medicine.

Question:

In contemplating reform, the stakes are high and there is tremendous room for error. We do not want to waste time, energy, or lives going down the wrong road. What should we be mindful of when changing the status quo? Can each of you identify pitfalls that we must avoid? What lessons can we learn from past unsuccessful health reform efforts?

Response:

I was heavily involved in this issue in 1993 when President Clinton introduced his universal coverage bill. At the time, it seemed that most people wanted to be assured that they could keep the coverage they have, while at the same time being willing to help others obtain insurance. I

think that the security of keeping the coverage they know and trust was and still is central to American thinking on the issue.

But what President Clinton proposed was a program that would take most people out of their existing plan and put them in some other source of coverage. This was a bad mistake. Moving people out of their current source of coverage to an unknown program ignored people's desire to keep what they have. Since people tend to fear the unknown, most turned against the plan.

It may yet be time for us to move away from employer coverage. Employers seem to have few ideas for controlling costs and many want out to get out of the business of providing health insurance. But this time we need to be sure to listen to people closely and put less emphasis on brave new worlds imagined by "policy wonks". I guess that includes me.

Questions for Senator Kerry

Question:

My top three health care priorities this year are extending coverage to as many uninsured kids as possible, addressing the small business health care crisis, and pursuing a federal reinsurance policy that will reduce premiums and stabilize the group purchasing market. Can you comment on the extent to which each of these will lay the groundwork for broader reform initiatives we consider this Congress and beyond?

Mr. Sheil's mentioned in his testimony that the U.S. is currently spending $6,500 per person, which is nearly twice the per-capita spending in Canada and most European countries. The delivery of our health care is uneven – not all patients are treated the same. What can be done to reduce the cost of health care and to provide more equal care to patients?

I am concerned that in order for companies to be competitive they are reducing their health care benefits or increasing the employee's share of the premiums. Do you see evidence of this trend and is it a trend that will continue?

Are we adding to our health care costs by allowing the number of the uninsured to continue to grow? Are health care costs often high for those without insurance because they usually do not receive preventive care and do not seek medical care until their health problem has escalated?

Recently, the New York Times published a survey which showed that 60 percent of Americans would be willing to pay more in taxes in order to guarantee health care for all – including 46% of Republicans polled. Do you think a revenue increase is an appropriate way to finance expanded health care coverage? Do you have other suggestions on how to finance expanded coverage?

Response:

This question has several parts.

Proposal as Groundwork for Future Reform

I believe that the small business insurance crisis and access to coverage in the individual market is driven by a lack of competition among insurers. Insurer administrative costs and profits grew by an average of about 12 percent per year between 2001 and 2005, while the cost of the health services covered by these plans grew by only about 8.5 percent per year. How can insurer overhead costs be growing faster than the cost of health services with all of the advances in medical technology? Insurer profits in the health insurance industry were $40 billion in 2006, most of which we believe was attributed to the small group and individual markets.

Administrative costs and profit are equal to up to 41 percent of benefits costs in the individual market. Many states have three or fewer major insurers, which is far short of what it takes for the insurance market to be competitive. Conditions are often similar in the small-group market. Failure to intensify competition will increase the number of uninsured and threaten the insurance industry by driving the nation towards a government-run health system. Some ideas on increasing competition are presented below.

Cost Control

With the growth in medical technology and the aging of the population we have to accept that health care costs will continue to grow faster than people's incomes. We cannot look forward to tomorrow's miracles of modern medicine without being prepared to pay for them. However, through increased competition and healthier lifestyles we can slow the rate of growth in spending without jeopardizing advances in medical technology. For example, reducing the rate of growth in health spending by just one half of a percentage point per year could save up to one trillion dollars over the next ten years.

Some argue that we should regulate provider payments to limit the growth in health care costs. This could be done through a single-payer system or even through our existing multi-payer system. But this is a form of health care rationing that I do not think we are ready for. I believe that the only viable approach to cost containment is to implement a collection of policies designed to reduce costs within the context of our current system. Some ideas include:

- **Maximize Competition in Health Care:** Maximize incentives for price competition among insurers by strengthening consumer demand and access to lower-cost health plans. Key to this is changing the tax code so it no longer encourages increased health care consumption (i.e., people must not be able to reduce their taxes by increasing their consumption of health care and health insurance. These steps include:
  - — Eliminate the tax exclusion for employer health benefits. This can be done without increasing taxes by making other adjustments to the tax code such as a fixed deduction that, unlike the President's proposal, allows the deductible amount to increase in proportion to growth in health care cost;
  - — Eliminate flexible benefits plans;
  - — Assure that all workers have access to HMOs, HSA health plans and other products that provide incentives to control costs; and
  - — Require employers to use a fixed employer contribution where workers must pay the full cost of adopting more costly health plans.

- **Public Health Initiatives:** Nothing saves money like public health. We should adopt polices with "teeth" designed to adopt healthier lifestyles. Examples of such policies include:
  - — Impose a substantial increase in tobacco taxes;
  - — Prohibit the use to trans-fats in commercial food products;
  - — Impose significant taxes on soft drinks and prohibit their sale in schools;
  - — Require states to have motor cycle helmet laws as a condition of receiving federal transportation funds;
  - — Continue education on obesity and tobacco use; and
  - — Consider other financial motivators for individual responsibility.

- **Targeted Care for Chronically Ill without Health Insurance:** In the absence of universal coverage, we should adopt initiatives to seek out those whose health is actually suffering from a lack of primary care due to a lack of health insurance. Targeting the uninsured most likely to incur avoidable complications and hospital stays, such as the chronically ill, would reduce spending and provide a meaningful stop-gap measure with real savings until universal coverage is achieved.

- **Use Cost-effectiveness as a Criterion for Drug Approval:** Under this policy, the FDA would require drug manufacturers to demonstrate that each new drug is substantially more effective than other existing lower cost drugs now in use.

- **Implement Effectiveness Research:** Fund clinical trials and other research to evaluate the effectiveness of alternative therapies. Exerts are divided on whether this would actually save money, since these results could indicate that the more expensive technologies and procedures are most effective. However, providing this research together with increased incentives for competition among organized delivery systems could be a vital step in reducing costs through the elimination of inappropriate utilization.

None of these ideas are magic bullets and all would face opposition. Realistically, they should be adopted only in the spirit of shaving off up to one percentage point from the annual rate of growth in health spending.

Trend Towards Reduced Employer Benefits

Many employers are now embracing the concept of defined contribution health benefits. In concept, the defined contribution model provides a fixed amount of money for workers to use in purchasing coverage, with no guarantee that those amounts will be adequate to purchase a given amount of services. This differs from the traditional defined contribution plans, where the employer's plan covers a defined list of medically necessary services regardless of cost.

This movement spawned the creation of "consumer directed" health plans. These are high deductible plans where the individual is expected to "shop" for services on the basis of price. These plans often provide information on providers and provider prices for services that the consumer can use to make their choices. These plans can be in the form of an HSA where

individuals can make a tax exempt contribution to an account that is used to pay for services below the deductible amount.

In my view, this is a reflection of a growing unease among employers about what the future holds for health spending. As discussed above, employers seem to have run short of ideas on how to control costs. They see themselves as at the mercy of spiraling health care costs that they are unable to control. The movement to the defined contribution model is a reflection of the employer's wish to get out of the business of providing health care to their workers.

Reinsurance Model

The polls of the uninsured indicate that the majority of Americans want to retain the coverage they now have, but with reduced increases in premiums. For most, this means retaining their existing employer coverage. The reinsurance model could be very effective in preserving the coverage now provided through employers.

The program would effectively limit employer spending by drawing upon public funds to cover high-cost cases. It could also stabilize premium growth for individual employers when one or more group members become ill. The cost of administration for reinsurance would be minimal because it requires processing costs for only those with high spending (probably fewer than 10 percent of the insured population).

Reinsurance could be funded with an assessment on insurance. This would facilitate the spreading of risk across insurers, but would not actually reduce the overall average amount spent by employers. Reinsurance would reduce employer costs only if it is funded through some external revenue source (e.g., general revenues).

A reinsurance program that covers all employers would inevitably involve paying substantial amounts to employer plans, regardless of the profitability of individual firms. Whether we should use scarce public funding in this way is an open question.

Spending for the Uninsured

We estimate that the uninsured will consume about $82.2 billion in health services in 2007. About half will be paid out-of-pocket and half will be in the form of free care, including public hospitals, free clinics and uncompensated care from private providers.

We assume that if they were to become insured, their utilization would be similar to that reported by insured people with similar age, sex and health status characteristics. Under this assumption, spending for the newly insured population would increase by about $54 billion due to increased utilization of health services.

It is true that there would be fewer costs for complications from untreated health conditions. However, these savings would be more than offset by increases in utilization of services that are more elective in nature such as mental health or corrective orthopedic surgery. Thus covering the uninsured will not in itself reduce health care costs.

Financing Coverage

To be blunt, the only way to achieve universal coverage is to take money away from people who have money and give it to people who do not have money, presumably in the form of insurance. You can draw it from any number of sources, and there are always "smoke and mirrors possibilities". But in the end, some form of transfer of money will be necessary.

Questions from Senator Kyl

Question:

The US Census Bureau estimates that nearly 47 million Americans were uninsured in 2005. In Arizona, the nation's fastest growing state, the number of uninsured climbed to nearly one million people in 2005. Uninsured statistics include individuals whose insurance status changes, such as an individual who leaves one job and goes without coverage for several weeks before starting a new job. Out of the 47 million uninsured Americans, how many Americans are chronically uninsured? How old are these individuals? And, what is the primary reason for the lack of coverage?

Response:

Research has generally shown that about 75 percent of the uninsured have been without coverage for more than a year. The remaining 25 percent appear to be going through some form of transition such as loss of employment or divorce, which leaves them uninsured for relatively shorter period of time.

We have estimated that there are about 31.4 million people who were uninsured all year in 2005. Their distribution by age is:

	Number (millions)	Percent
Under age 19	5.3	16.9%
19 - 24	5.5	17.5
25 - 34	7.0	222.3
35 - 44	5.4	17.2
45 - 54	4.6	14.7
55 - 6	3.4	10.8
65 and older	0.2	0.6
Total	**31.4**	**100%**

Question:

As Congress considers health care reform, one idea is to expand federal public health programs such as Medicaid and SCHIP to cover the uninsured. Other proposals may include an employer mandate or defined contribution. In your testimony, you state that despite federal and state efforts to expand such programs, the number of uninsured continues to increase by

approximately one million people per year. Yes or No- As the Finance Committee considers health care reform principles and proposals, the Committee should address the underlying causes of why individuals lack health coverage rather than merely cost-shifting to government, health care providers, taxpayers, and employers?

Response:

Yes. We should address the major issues that cause people to become uninsured as part of any effort to expand insurance coverage such as cost growth (discussed above) and cost-shifting. As I stated in my testimony, cost-shifting is a destructive cycle that generates new uninsured people every year. When government underpays for health services, as under Medicaid, it creates a payment shortfall for providers that is passed-on to privately insured people in the form of higher charges. This pushes up private insurance premiums resulting in more uninsured and increased Medicaid enrollment that then further increases payment short falls and cost-shifting.

For any health reform plan to be successful, it must end this cycle of cost-shifting and coverage loss. Ideally, Medicaid and SCHIP payment levels should be increased to levels sufficient to cover provider costs in order to relieve the pressure on private payer rates. This would cost between $20 billion and $30 billion (federal share of $11 billion to $17 billion). At a minimum, any increase in Medicaid or SCHIP eligibility should be accompanied by payment increases at least large enough to assure that the expansion does not increase the level of cost-shifting.

Questions from Senator Cantwell

Question:

My home state of Washington has been recognized as a high quality, low-cost health care state.

You all are no doubt familiar with the Dartmouth Research showing that there are wide regional variations in Medicare spending and that they are unrelated to health care outcomes. In other words, we spend a lot more money in some parts of the country than others, but we don't get better care for it. In fact, some of the highest quality care states in the country are among the lowest cost states.

Residents of high-spending areas in the country receive as much as 60 percent more care than those in low-spending areas. While the researchers say high-spending areas have greater frequency of physician visits, more frequent use of specialists, more frequent tests and minor procedures, and greater use of the hospitals and intensive care units, they find no evidence that people in high-spending regions have better health outcomes or are more satisfied with their care than people in lower cost areas.

What are your suggestions for tackling the wide regional variations in health care spending?

Should high quality, low-cost states like Washington continue to be penalized by a system that rewards inefficiency with more reimbursement?

What do you think other areas of the country can learn from an efficient health care state like Washington?

Response:

Correcting for geographic differences in medical practice patterns should be based upon an improved understanding of the medical effectiveness of alternative therapies rather than mere changes in the payment system. The Dartmouth and other related research suggests both over-use of services in some areas and under-use of services in others. In fact, striking differences in utilization patterns can be detected even within individual geographic areas. Often, these differences reflect that little is known about the relative merits of alternative therapies.

Many believe that the best solution to spurious geographic differences in medical practice is to develop and promulgate evidence-based research that provides guideposts for physicians to use in selecting appropriate treatment for patients. For example, there are proposals to fund clinical trials and assessments of existing research to identify the safest and most effective approaches available for patients under various circumstances. This material could be distributed to physicians through medical journals and conferences to begin the process of aligning medical practices.

The impact that this would have on overall health spending is unclear. For example, one study showed that many health attack patients did not receive beta-blocker medications that have been shown to reduce the risk of additional heart attacks. Other studies have shown that some treatments provide little benefit to patients. Presumably, evidence research will increase utilization where appropriate while reducing utilization in areas where there is evidence of over-use. The net effect on spending is impossible to predict.

Questions:

I recently joined with a number of my colleagues from both sides of the aisle, including Senators Wyden, Conrad, Salazar, Lott and Crapo, in committing to work in a bipartisan way to tackle health care reform. There have been a number of diverse outside groups coming together as well around the need for health care reform, including employers, providers, advocates, and others. Many states have stepped up to the plate on reform, including my home state of Washington, which recently passed significant legislation to cover kids.

What advice would you give to my colleagues and me, who want to work together on achievable solutions? What is the one thing that we could do this year, in addition to reauthorizing SCHIP, that would make a measurable difference? down coverage offered at work, presumably because they can't afford the premiums. Can you say more about trends in employer coverage? Do you expect that 6 million number to grow? Will employers continue to offer dependent coverage?

Response:

This question has two parts pertaining to me.

Making a Measurable Difference this Year

Advances in cost containment are the single most important thing we can do to stop and reverse the unending growth in the uninsured population. In my above response to the question from Senator Kerry, I identified several aggressive cost containment initiatives that could be implemented with minimal cost to the federal government. These include steps for: increasing competition in the insurance industry; public health initiatives; targeted outreach to chronically ill uninsured people; and increased use of cost-effectiveness research.

The most important of these ideas is to eliminate the tax exclusion for employer health benefits that provides incentives for people to over-consume health care. This can be done by replacing the exclusion with a fixed tax deduction for privately insured people as proposed by the President. This approach allows people to reduce their spending on health care without loss of tax benefits.

In its current form, the President's plan would eventually increase taxes because, under his proposal, the amount of the deduction would not keep pace with the growth in health care costs. This tax increase could be averted by simply indexing the deduction amount to the growth in health spending, rather than just the CPI (general inflation) as in the Presidents plan.

Other initiatives include:

- Assure that all workers have access to lower-cost coverage options such as HMOs and HSA health plans;
- Require employers to use a fixed dollar employer contribution where workers must pay the full cost of adopting more costly health coverage alternatives;
- Impose a substantial increase in tobacco taxes;
- Prohibit the use of trans-fats in commercial food products; and impose significant taxes on soft drinks and snack foods and prohibit their sale in schools;
- Require states to have motor cycle helmet laws as a condition of receiving federal transportation funds;
- Continue education on obesity and tobacco use;
- Target chronically ill uninsured patients most likely to incur avoidable complications and hospital stays for primary care services; and
- Require drug manufacturers to demonstrate that each new drug is more effective than other existing lower cost drugs now in use for the same purpose.

Workers Who Decline Coverage When Offered

Recent data from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, indicates a reduction in the percentage of workers with employer coverage between 2002 and 2006. Key findings are:

- The percentage of employers offering coverage declined from 66 percent in 2002 to about 61 percent in 2006;
- The percentage of workers in insuring firms who are eligible for the plan declined from 81 percent in 2002 to 78 percent in 2006;

- The percentage of eligible workers taking coverage fell from 84 percent in 2002 to 82 percent on 2006.

Earlier studies indicated that through the 1990's, the decline in employer coverage was primarily due to an increase in the percentage of workers who go without insurance rather than taking the coverage offered by their employer.

Contrary to popular perception, employers have not been increasing the proportion of the premium that must be paid by the worker. In fact the average percentage of the premium paid by the worker has remained roughly unchanged since 2002, at 16 percent for single coverage and about 27 percent for family coverage. This means that premiums have been increasing at roughly the same rate for both employers and employees. Thus, the increase in the number of uninsured workers who decline coverage when offered is due to the underlying growth in health spending rather than a shift of costs to workers.

Nearly all employers who offer health insurance provide coverage for dependents. It is unlikely that employers will discontinue coverage for dependents. Instead, employers are more likely to reduce or eliminate the employer contribution amount as is the case for in many small firms. In fact, some insurers in the small group market will not insure a group unless dependents are eligible. As discussed above, the data indicate that for now, the proportion of the premium paid by employers is stable.

Question:

Several of you talked either in your written statements or in the question and answer session about state reform efforts. Washington state has been a leader in building on existing public programs to expand access to increasing numbers of the uninsured. In fact, our state recently passed legislation to cut the number of uninsured children in half. Can you talk about how states are leveraging existing programs to expand coverage and the importance of building what we already have in place to achieve broader coverage?

Response:

Building upon existing programs is one way of expanding coverage rather quickly. However, not all states have adopted this approach. About half of the states chose to establish a separate SCHIP program rather than expanding children's coverage through Medicaid. The Massachusetts model combined a Medicaid expansion with a newly established "connector" with premium subsidies for private coverage. Expansions in private coverage through premium subsidies are often preferred because it does not add to the cost-shift and is free of the stigma that often accompanies public coverage.

Each state is unique. For example, the Washington Basic Health Plan is separate from Medicaid and is already based upon a premium subsidy model. The MinnesotaCare program is similar. These states can expand subsidized coverage through these programs rather than building upon Medicaid. However, other states with only a Medicaid program would need to set up a new program to expand coverage through private insurance with premium subsidies.

There are limitations to what states can do. States generally cannot receive federal Medicaid matching funds to cover non-disabled adults without children, which is the largest share of the uninsured population living below the federal poverty level (FPL). ERISA also preempts states from implementing requirements for employers to contribute to the cost of covering their workers (to what extent is not clear). Lower-income states also lack the tax base to substantially expand publicly subsidized coverage. While several states may be able to significantly reduce the number of uninsured in their state, federal action will be required to move the entire nation towards universal coverage.

STATEMENT OF SENATOR GORDON H. SMITH
U.S. Senate Finance Committee
"Charting a Course for Healthcare Reform: Moving Toward Universal Coverage"
March 14, 2007

Thank you, Chairman Baucus and Senator Grassley, for providing the Finance Committee with an opportunity to explore the important topic of providing universal access to health insurance coverage. This is a timely and important hearing, and I hope it marks the start of Congress' commitment to a thorough and thoughtful discussion of how to reduce the number of uninsured in our nation. I look forward to learning more about the recommendations of the Citizen's Healthcare Work Group as well other ideas for expanding access to health insurance coverage that the panel of experts you have assembled will present us with today.

Ensuring that all Americans have access to affordable, comprehensive health coverage has been and continues to be one of my key priorities as United States Senator, and I hope the 110th Congress is able to make progress toward that goal. Guaranteeing universal coverage will require the support and financial commitment of federal and state governments, employers and individuals. The challenges that have prevented the nation's healthcare system from providing greater access to health coverage cannot be linked to any one entity or industry. Our problems are shared, which means the necessary solutions must be crafted, vetted and implemented cooperatively.

I supported the formation of the Citizen's Healthcare Work Group when it was created as part of the Medicare Modernization Act (MMA) in 2003. I believe the Group has done an excellent job of assessing the views and concerns Americans share in regard to healthcare reform. Over the last few years, I have followed their work and I am intrigued with many of the concepts underlying the recommendations they issued last fall.

I find the Group's call to focus more effort on universal catastrophic coverage a very promising concept. I believe such a policy could provide a number of ameliorative effects in health insurance markets, in addition to providing individuals protection against financial harm during periods of healthcare difficulties. For instance, guaranteeing universal catastrophic coverage would capture those individuals currently lacking health insurance, providing them a point of access into the healthcare system. Employers who currently offer comprehensive health coverage also stand to benefit from such a policy because it would indirectly provide them relief from rising healthcare costs. Of course, universal catastrophic coverage is only the first step needed toward solving the problem of the uninsured. It also would be necessary to create more affordable "first dollar" coverage options in the existing commercial market, so that taken together, individuals would have quality, comprehensive health coverage.

I also am encouraged by the priority the Group gave to enacting broad cost control mechanisms alongside its proposed model of coverage expansion. The nation's

healthcare system must place more emphasis upon preventing costly healthcare conditions and better managing chronic health conditions if they should develop. Any gains we make in expanding access to healthcare coverage would be overwhelmed in the next few years by spiraling healthcare costs. Congress has not paid much attention to legitimate cost control policies in the past, but I am hopeful this Committee can help reverse that trend and begin a thoughtful debate on the issue this year.

One policy that the Group did not directly address in its recommendations was that of a personal health coverage mandate. Over the last decade, more and more Americans have come to agree that healthcare is a right in the U.S., but with that right must come responsibility. Individuals, businesses and the government must share in the effort required to create a universal health coverage system. For individuals in particular, I believe that should include a mandate, enforceable through the personal income tax system. Similarly, employers and businesses must contribute to the cost and administration of health coverage, especially in helping guarantee that there are affordable options in the market for individuals to purchase. I am working on a proposal that would incorporate a number of these concepts—including the coverage mandate—and hope to introduce it with bipartisan support in the coming months.

That proposal will very likely target the small business community, which has struggled for decades with finding affordable coverage options in the commercial market. Nearly 60 percent of the 46 million uninsured Americans are employed by small businesses. Even those firms that have been fortunate enough to secure affordable coverage for their employees may find that they have to drop it just so they can keep their doors open. If cost trends continue to hold, thousands more individuals employed by small businesses will join the ranks of the uninsured in coming years.

The federal government needs to consider innovative public/private partnerships to expand access to health insurance for our small businesses. Existing proposals, like Association Health Plans, have become mired in politics over the past several Congresses. To make progress on this issue, members from both parties need to rally around common principles such as pooling risk and portability of coverage. Moving forward in a bipartisan manner is truly the only way we will ever make significant gains in expanding access to health insurance coverage. I hope the proposal I am developing will come to be viewed as a thoughtful, reasonable approach to the problem of the uninsured by both my Republican and Democratic colleagues.

I cannot let the occasion of this hearing pass without recognizing the work of my colleague, Senator Ron Wyden, on the issue of healthcare reform. He and Senator Hatch are the original authors of the provision in the MMA that created the Citizen's Healthcare Work Group. I very much appreciate the concepts underlying Senator Wyden's *Healthy Americans Act*, especially the plan's emphasis on making the existing tax treatment of health insurance premiums more equitable. Last year, the two of us worked in a bipartisan manner to develop the *Catastrophic Health Coverage Promotion A*ct, a bill that will help provide more uninsured Americans access to basic catastrophic coverage, much like what is called for in the Citizen's Healthcare Work Group's proposal. I look

forward to working with him this Congress to advance that measure as well as others aimed at reforming the nation's healthcare system.

I am optimistic that Congress will make progress toward expanding access to health coverage this year, especially with the reauthorization of the State Children's Health Insurance Program (SCHIP) on the agenda. The State of Oregon could cover nearly all its uninsured children if SCHIP eligibility were expanded to 300 percent of the Federal Poverty Level. I believe Congress should reauthorize SCHIP and provide sufficient funding to help states meet universal coverage goals for children. SCHIP is a program with broad bipartisan support, and its reauthorization could provide the opportunity for the consideration of broader healthcare reforms that could ultimately expand access to health insurance for all Americans, regardless of their age.

Thank you.

Statement of Senator Craig Thomas
Finance Committee Hearing: "Charting a Course for Health Care Reform: Moving Toward Universal Coverage"

March 14, 2007

Like most folks, I agree that there are things broken in our health care system. I support efforts to try to make it just a little bit easier to get and keep good health insurance. I would also like to make insurance portable so workers could change jobs without losing it. Mr. Chairman, I hope that by working on a bipartisan basis, we can come up with some reasonable, commonsense solutions to do just that. I want to make genuine reforms that help working people access private health insurance, but I believe we can do it without having the Federal Government take over and run the health care system. Americans deserve a government that they can afford.

As the Finance Committee debates various health care reform proposals, we will be talking about dramatic shifts in current policy. To that end, it is absolutely imperative that the American people understand what these proposals actually do, get all the facts about how they will be implemented, and most importantly, how these proposals will affect the pocketbooks of all Americans. I do hope that we will not just spend a lot of time talking about the benefits without leveling with folks about how much it will cost. It is always easy to talk about benefits. It is much more difficult to talk about how you are going to pay for those benefits. We need to empower the American people so that they can make informed choices. Given all the facts, will people want a government run system? Will people be forced to give up their employer sponsored plans for a plan managed by the Federal Government? Do they want to be denied the right to buy private health insurance in competition with the Government? Will they be forced to buy through a Government agency whether they like it or not? Are Americans willing to pay excessively high taxes on their wages to have the Government offer health care to everyone?

I think the answer to these questions is no. Most Americans I know, especially those in Wyoming, already think we have too much government. The people that I represent do not all believe that having the Government provide universal coverage, as some would propose, is going to solve our problems. I believe we need to preserve the things about our health care system that we know are second to none: the quality, the access to science and technology, and the fundamental freedom to choose what product we want as consumers. There is no question that we all want to help folks purchase private health insurance, but how do we do it without bankrupting the Federal government? I do hope that we will not, as some proposals suggest, tear down the whole health care system in this country and try to recreate it in the image of Big Government.

As Congress debates whether the Government should move toward a universal health care system, I hope that we would reject mandatory purchasing cooperatives and the idea that the Government should decide what kind of health insurance people should buy. When we focus on the parts of the system that are broken, when we provide a workable plan so people can keep bridge coverage when they lose their jobs and retain their insurance until they get a new job, when we deal with medical liability, when we force the Government to reduce paperwork and be more effective and efficient, when we allow free individuals and institutions to voluntarily pool

to buy health insurance, and when we reform entitlement programs so moderately low income folks can buy private health insurance, then I think we are on the right track. Ultimately, this is just a fundamental difference that exists among Republicans and Democrats – what is the role of the federal government? Should we have Government setting up insurance pools for everyone and controlling the purchase of health care? I would argue that we are not going to find cost consciousness – nor will we find efficiency – in a Government run plan.

I understand we will hear from some consumer and provider groups who have quite a bit of expertise in this area. I look forward to hearing your testimony.

Thank you, Mr. Chairman.

Statement

For the Record

of the

American Medical Association

to the

Committee on Finance
United States Senate

RE: Charting a Course for Health Reform: Moving Toward Universal Coverage

March 14, 2007

Statement

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RE: Charting a Course for Health Reform: Moving Toward Universal Coverage

March 14, 2007

The American Medical Association (AMA) is pleased to share the views of our physician and medical student members on expanding health insurance coverage and access to care. Enabling every American to have health insurance is a top priority for the AMA and America's physicians. We have developed a comprehensive proposal to expand coverage of health insurance and improve access to care that we believe will enable uninsured individuals and families to obtain affordable coverage, with financial assistance for those with low incomes.

The Problem

According to the latest U.S. Census Bureau data, an estimated 44.8 million Americans, or about 15.3 percent of the population, were uninsured in 2005, approximately 9 million of whom were children. Physicians see first-hand, on a daily basis, the devastating consequences of not having health care coverage. Research shows that uninsured patients live sicker and die younger. The uninsured often postpone preventive care and going to the doctor until their health problems reach crisis proportions, leading to more difficult and more costly conditions to treat.

Patients without health insurance are less likely to receive treatment after injuries or diagnoses of chronic diseases, according to a study commissioned by the Kaiser Family Foundation and led by Jack Hadley, Ph.D. of the Urban Institute. Published in the March 14, 2007, *Journal of the American Medical Association* theme issue on Access to Care, the study found that following an accidental injury, the uninsured are less likely than the insured to receive any medical care (78.8 percent vs. 88.7 percent). Likewise, following diagnosis of a new chronic condition, the uninsured are less likely to receive care (81.7

percent vs. 91.5 percent). In addition, the uninsured with an injury are about twice as likely to forgo recommended follow-up care (19.3 percent vs. 9.2 percent), which is also the case with new chronic conditions. The study indicated that the uninsured are more likely to report that they have not fully recovered and are no longer being treated following an accident. In addition, seven months after the initial diagnosis of a new chronic condition, those who were uninsured reported worse health status than the insured with similar conditions.

Being uninsured has especially negative consequences for the health and well-being of children. When children lack health insurance coverage, they are less likely to receive timely immunizations or see a doctor when they are sick. They tend to develop conditions, such as asthma, that could have been treated more affordably and effectively if diagnosed sooner. Having insurance leads to better access to care and better health outcomes, particularly for children with serious illnesses and disabilities.

The Solutions

The AMA Proposal

The AMA has long advocated for a health care system in which every American has health insurance coverage. Our broad proposal for reform would dramatically increase the number of Americans with health insurance while putting patients first in choosing an insurance package that best meets their needs. The AMA proposal allows for the continuation of employment-based insurance in the private sector, while encouraging new sources of health insurance that would be available to both the uninsured and the currently insured. Under our proposal, individuals who are satisfied with their existing coverage will be able to maintain that coverage. Those who are uninsured or dissatisfied with their current coverage will be able to purchase the coverage they want. The following are the main elements of the AMA proposal, described in detail below:

- enable individuals and families to obtain coverage of their own choosing;
- assist those who need financial help obtaining health insurance through tax credits or vouchers; and
- foster market reforms that encourage the creation of innovative and affordable health insurance options.

1. Individual Choice

The ultimate solution to solving the problem of the uninsured is to encourage and enable individual ownership and selection of health insurance. Individuals should be able to choose for themselves and their families the health insurance plan that best matches their needs. Currently, only one in six employers offering health insurance offers a choice of plans. People are effectively locked into the plans employers offer, which are subject to change from year to year or with a change in employment. In contrast, under the AMA proposal, individuals, rather than employers, would choose the kind of coverage that meets their needs, whether through an employer or not. Individuals could keep or change

their plan regardless of their employment status. Accordingly, people would have more say about the types of benefits and plan features they like, which would increase competition and innovation in the health insurance market. This would result in better, more affordable coverage options that are within reach of more people.

2. Tax Credits

In order to facilitate broad coverage and individual ownership of health insurance, tax policy needs to change. For those who need financial assistance obtaining health insurance, the AMA proposal would provide subsidies through individual tax credits or vouchers. Currently, the government subsidizes the purchase of health insurance by excluding expenditures on health insurance from an individual's or family's taxable income, but only if insurance is obtained through an employer and usually only on that portion of the premium paid for by the employer. The self-employed can deduct 100 percent of their insurance costs. However, no tax break is given to individuals who purchase their own health insurance, or to workers whose employers do not offer coverage (i.e., all of their income is taxed). And, if they want health insurance, they must buy it without any subsidy or other financial assistance.

The current tax exclusion is inequitable and regressive because it provides a higher subsidy to those with higher incomes. However, the uninsured, most of whom work or are in a family headed by a worker, do not have access to the health insurance subsidies enjoyed by others. The AMA plan would expand health insurance coverage by redirecting or capping the current health insurance subsidy from higher to lower income groups (i.e., to those who need it most) through tax credits. Employer contributions for health insurance would be reported by employees as taxable income and individuals would directly subtract health insurance tax credits from their tax bills.

Expanding health insurance coverage through the use of tax credits should be guided by certain principles. The size of tax credits should be inversely related to income, so that larger credits would be available to families and individuals in the lower tax brackets. In addition, the tax credits should be refundable so that those with low incomes would receive a check or voucher from the government, even if they owe less in taxes than the value of the tax credit. Those with higher incomes would be able to use their tax credits to partially offset their tax liability. Tax credits or vouchers should also be advanceable so that those with low incomes and those who cannot afford the monthly out-of-pocket premium costs would be able to purchase coverage without waiting for the year-end tax reconciliation process.

The size of the tax credits should also be large enough to ensure that health insurance is affordable for most people. The credits must at least be sufficient to cover a substantial portion of the premium costs for individuals in the low-income categories, and at the lowest income levels the credit should approach 100 percent of the premium. In addition, the size of tax credits should vary with family size to mirror the pricing structure of insurance premiums, with premiums for family policies being less than the sum of premiums for individual members. Tax credits should be fixed-dollar amounts for a

given income and family structure. Making the credits independent of expenditures for health insurance will encourage individuals to be cost-conscious and discourage over-insurance. Moreover, the credits should be capped in any given year to prevent over-insurance as well.

Tax credits should be contingent on the purchase of health insurance, so that if insurance is not obtained the credit is not provided. This principle provides a strong incentive for people to obtain health insurance voluntarily. Finally, tax credits should be applicable only for the purchase of health insurance and not for out-of-pocket expenditures. Separate subsidies should be considered for those individuals whose out-of-pocket health spending is unusually high due to chronic disease or health catastrophe.

3. Insurance Market Reform

The AMA supports the development of new health insurance markets that offer a wide range of affordable coverage options. We also support alternative means of pooling risk along the lines of existing models such as small group purchasing alliances and Internet-based health insurance vendors. We believe that empowering people with tax credits, health insurance vouchers, and freedom of choice would dramatically transform today's health insurance markets. The new system would make health plans more responsive to patients, rein in premiums and health care costs, and stimulate the development of new forms of health insurance that better meet the wide range of needs of individuals and families.

The AMA recognizes that in order for tax credit proposals and individual insurance to be viable, a number of market and regulatory reforms are necessary. Numerous state and federal health insurance market regulations have made it more difficult for some individuals and employers to find affordable health insurance in some regions of the country. Burdensome and complex market regulations that were intended to protect people with health risks – benefit mandates, guaranteed issue, and strict community rating – have often had unintended consequences by driving up premiums for younger, healthier people, leading them to drop coverage.

We propose streamlined, more uniform market regulations that reward, not penalize, insurers for taking all types of patients. A more rational regulatory environment would: assist high-risk individuals without unduly driving up health insurance premiums for the rest of the population; give individuals incentives to be continuously insured; and enable rather than impede private market innovations such as health savings accounts (HSAs), health reimbursement arrangements (HRAs), other forms of consumer-driven health care plans, defined contribution plans, and new forms of coverage. In particular, the AMA supports the following principles for health insurance market regulation:

- there should be greater national uniformity of market regulation across health insurance markets, regardless of type of submarket, geographic location, or type of health plan;

- state variation in market regulation should be permitted if the impact on cost does not make coverage unaffordable and as long as the number of uninsured does not increase;
- risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges;
- strict community rating should be replaced with modified community rating, risk bands, or risk corridors;
- insured individuals should be protected by guaranteed renewability;
- insured individuals who want to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage;
- guaranteed issue regulations should be rescinded; and
- the regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:

    - legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed;
    - benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and
    - any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

Everyone pays inflated premiums for health insurance because of the costs associated with treating the uninsured, and these inflated premium rates create an additional barrier to expanding coverage to the uninsured. The AMA believes that those with higher incomes have a responsibility to obtain health insurance. Specifically, we support requiring individuals and families earning more than 500 percent of the federal poverty level (FPL) to obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care.

Protecting Vulnerable Populations – SCHIP

The AMA favors the use of tax credits over public program expansions as a means of providing coverage to the uninsured. However, in the short term, in the absence of comprehensive reform, the AMA supports special efforts being made to enroll all individuals who are eligible for public sector programs, such as the State Children's Health Insurance Program (SCHIP), with the goal of providing health insurance coverage to otherwise uninsured groups. We think it is critical to enhance outreach efforts to enroll all children who are currently eligible for but not yet enrolled in Medicaid and SCHIP.

SCHIP provides a significant health insurance safety net for low-income children. By any measure, SCHIP has been a success in expanding coverage for children. The program has helped to significantly reduce the number and percentage of low-income children without coverage since its creation in 1997. Despite this progress, of the nine million children who are uninsured, about six million children are eligible for health

insurance coverage under SCHIP or Medicaid but are not enrolled. The AMA supports focusing first on enrolling these children.

A key reason why millions of eligible children are not participating in SCHIP or Medicaid is that enrollment and re-enrollment procedures are often cumbersome. The AMA supports state efforts to maximize outreach and enrollment of SCHIP-eligible children using all available state and federal funding. The AMA also supports streamlining the enrollment process within their Medicaid and SCHIP programs by: allowing a one-stop shopping system to prove eligibility; allowing mail-in applications; developing shorter application forms; coordinating application processes among multiple low-income programs; placing eligibility workers in strategic locations to best reach potential beneficiaries; and administering Medicaid and SCHIP programs through a single state agency. AMA policy encourages physicians, in those states where it is allowed, to enroll children in adequately funded Medicaid and SCHIP programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be eligible.

Another critical factor in the success of SCHIP is ensuring that a sufficient number of physicians participate as providers in the program. Therefore, SCHIP payment rates need to be at a level that adequately covers physicians' costs in providing care to SCHIP beneficiaries.

States will need additional federal SCHIP funds to pay for the increased enrollment of all eligible children from lower-income families. This is in addition to increased funding necessary just to maintain coverage for those beneficiaries currently enrolled in SCHIP. Unlike Medicaid, an entitlement program whose federal funding increases automatically to compensate for increases in health care costs (as well as increases in case loads), SCHIP is a block grant with a fixed annual funding level. As a result, the federal SCHIP funding that states receive is not keeping pace with the rising cost of health care or population growth.

State efforts to expand health insurance coverage come at a time when future funding is uncertain, and a number of states are projected to face significant shortfalls in their SCHIP funding this year. Although Congress approved, as part of the National Institutes of Health Reform Act of 2006 (Public Law No: 109-482), an amendment to redistribute unspent SCHIP allotments from fiscal years 2004 and 2005, these funds only delay the date that states will start experiencing shortfalls until early May 2007. The remaining shortfalls for the fiscal year are projected at over $716 million. The continued success of SCHIP is largely dependent on adequate future federal funding.

State Demonstrations

The AMA favors providing states with the support and flexibility needed to improve coverage rather than dictating the details of specific mechanisms. With recent evidence of successful state efforts and planned initiatives to increase coverage for uninsured children, the AMA believes it is important to support state autonomy in extending health

insurance coverage. Thus, the AMA supports giving state governments the freedom to develop and test different models for improving coverage for patients with low incomes. We also support changes in federal rules and federal financing to support the ability of states to develop and test such alternatives.

Coalition Activities

The AMA is working to achieve our policy recommendations with the Health Coverage Coalition for the Uninsured (HCCU), a diverse coalition of major national organizations (including AARP, American Hospital Association, the Chamber of Commerce, America's Health Insurance Plans, and Families USA) interested in decreasing the number of uninsured Americans, especially children. The HCCU proposes to provide coverage to the uninsured in two phases, the first of which is comprised of the "Kids First" initiative and support for state experimentation.

The HCCU "Kids First" initiative proposes to maximize existing public-sector coverage by improving enrollment of children who are uninsured but currently eligible for SCHIP and Medicaid. This would be accomplished by giving states the flexibility to deem low-income uninsured children eligible and enroll them in SCHIP or Medicaid when they qualify for other means-tested programs, such as free or reduced-price school lunches, food stamps, or the Women, Infants and Children (WIC) program. A more user-friendly, "one-stop" shopping system would make it easier to reach this critical targeted group of uninsured children.

The HCCU proposal also supports increasing health insurance coverage of children in the private sector, including through employer-sponsored health insurance, by creating a new family tax credit. The refundable and advanceable tax credit would be available to families with children with incomes up to 300 percent of the federal poverty level.

In addition, the proposal would establish a state demonstration program giving states flexibility to experiment with new, innovative approaches to expand health insurance coverage. Competitive grants would be provided to states which, unlike Medicaid waivers, would provide additional funding over and above current federal funds provided to states for Medicaid and SCHIP. More information about the HCCU consensus agreement is available at www.coalitionfortheuninsured.org.

In conclusion, the AMA recognizes that a variety of proposals are being advanced to expand health insurance coverage to the uninsured. We are committed to working with Congress to advance solutions to address the critical issue of reducing the number of uninsured Americans.

American Public Health Association
Working for a Healthier World
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March 14, 2007

The Honorable Max Baucus
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators:

On behalf of the American Public Health Association (APHA), the oldest, largest and most diverse organization of public health professionals in the world, dedicated to protecting all Americans, their families and communities from preventable, serious health threats and assuring community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States, please accept the attached document as testimony for the record for the hearing "Charting a Course for Health Care Reform: Moving Toward Universal Coverage" held March 14, 2007.

Thank you for your attention to and leadership on this important public health issue. We look forward to working with the Senate Finance Committee as it considers legislation related to universal coverage and health care reform. If you have questions, or for additional information, please contact me or have your staffs contact Courtney Perlino at (202) 777-2436 or courtney.perlino@apha.org.

Sincerely,

Georges C. Benjamin, MD, FACP, FACEP (Emeritus)
Executive Director

The American Public Health Association (APHA) is the oldest, largest and most diverse organization of public health professionals in the world, dedicated to protecting all Americans, their families and communities from preventable, serious health threats and assuring community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States.

For over 130 years, APHA has been at the forefront of numerous efforts to prevent disease and promote health. Since 1950, APHA has vigorously supported and promoted the concept of universal health care for all Americans. APHA is committed to the policy that all individuals in the United States deserve unencumbered access to quality health care services, regardless of race, gender, financial status and/or geographical location. We share your views that, with approximately 46 million Americans who are uninsured, the status quo is no longer acceptable. Increasing access to affordable health care needs to be multifaceted in nature—addressing both the public and private sectors and the rising costs overall as well as the costs to the individual. In addition, measures must be implemented to move the system toward preventing disease when possible and providing illness care in the most efficient and effective manner.

Portrait of the Uninsured

Two-thirds of the uninsured are from low-income households. Adults comprise eighty percent of the uninsured. In addition, there are more than 9 million children who lack health insurance coverage. There are also racial and ethnic disparities in rates of health insurance coverage. While thirteen percent of whites are uninsured, the problem is much more severe for the Native American and Hispanic populations, with one of three members of these populations finding themselves in the ranks of the uninsured. In addition, approximately one in five African Americans and Asian Americans is uninsured.

Although the non-elderly in this country primarily access health insurance through their employer, employers cannot be counted on to provide health insurance in the long-term, with employer-sponsored insurance becoming increasingly unaffordable. In fact, eight in 10 of the uninsured come from working families. Nearly 90 percent of uninsured children come from families where at least one parent works. It is therefore clear that people in working families are falling through the cracks, not able to access employer-sponsored insurance (ESI), and either not eligible for or aware of coverage available through Medicaid and the State Children's Health Insurance Program (SCHIP).

Why We Need to Cover the Uninsured

Accepting the inadequacies of our nation's current system of health insurance coverage is no longer an option. We all know that not doing anything to solve this problem is expensive, and leads to poor health outcomes. Total annual medical care expenditures for the uninsured are roughly $125 billion per year. Annual costs associated with uncompensated care are more than $40 billion and comprise roughly 3 percent of national spending for personal health services. The costs of uncompensated care are borne by the public sector—federal, state and local governments pay for roughly 85 percent of uncompensated care. In fact, if all uninsured individuals gained coverage, the estimated cost of their increased use of services—roughly $50 billion—is half the annual economic value of the foregone health of the population—more than $100 billion.

There is strong data showing that not having health insurance coverage leads to poor health outcomes. 18,000 excess deaths among people younger than 65 per year are attributed to lack of insurance coverage. Diabetes and stroke each account for a comparable number of deaths in this age group every year. Uninsured adults have a 25 percent greater risk of dying than adults with coverage. On the whole, people who are uninsured receive less care and experience poorer health outcomes following an accident or the onset of a new chronic condition than the insured population. Uninsured adults have higher rates of death resulting from hospitalizations when compared to insured individuals. Uninsured women with breast cancer have a 30 to 50 percent higher risk of dying than insured women. Uninsured pregnant women are less likely to go to the doctor before giving birth, which results in higher rates of infant mortality and more low-birth weight babies.

For kids, the effects of being uninsured are staggering. Uninsured children are more than three times less likely than insured children to have seen a doctor in the past year. Children who are uninsured have a higher incidence of preventable disease than those who are insured. Uninsured children are more likely to have common speech, hearing and behavioral problems that are common but treated within the privately insured population. Uninsured children who are asthmatic experience higher rates of hospitalization and use of emergency health services. Children without insurance have difficulty accessing specialty care, which is vitally important for children with chronic conditions or disabilities. Uninsured children are five times more likely than insured children to have an unmet dental need, which oftentimes causes children to be underweight and have poorer school attendance rates—ultimately impacting their parents' ability to go to work.

Covering All Kids: An Essential First Step

Although tackling the big-picture problem of the uninsured is going to take some time, and compromise, Congress can take a vital step to universal coverage this year by making strides to cover all children in the United States, taking advantage of the reality that 75 percent of uninsured children are currently eligible for but not enrolled in Medicaid or the State Children's Health Insurance program. As SCHIP is up for reauthorization this year, the Senate Finance Committee needs to prioritize the importance of covering uninsured kids and fully fund and improve SCHIP and Medicaid. States need ample dollars to cover all children eligible for Medicaid or SCHIP, and should be given financial incentives for covering more uninsured kids in their Medicaid and SCHIP programs. In addition to providing ample funding and financial incentives to states to cover all children eligible for but not enrolled in SCHIP and Medicaid, SCHIP reauthorization needs to address the quality and adequacy of the health coverage that children in SCHIP have and make changes that are necessary to ensure that they have a comprehensive, prevention-focused benefits package. Ultimately, the SCHIP reauthorization and congressional budget processes need to address include the following policy and legislative recommendations:

- Provide at least $60 billion in new funds over five years for SCHIP reauthorization. This amount would be enough to cover all current enrollees, enroll most children currently eligible for but not enrolled in SCHIP and Medicaid and provide coverage to pregnant women and legal immigrant pregnant women and children.
- Strengthen the federal standard for SCHIP benefits packages to make it comparable to the Medicaid benefits package, which includes coverage of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

- Provide adequate funding and give states the option to cover pregnant women and legal immigrant pregnant women and children in their SCHIP programs.
- Make revisions to federal law to give states the flexibility to deem children eligible for and enroll them in SCHIP or Medicaid based on information from other means-tested programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children and the National School Lunch Program.
- Allow states the flexibility to determine the citizenship status of SCHIP and Medicaid applicants.

A Framework for Universal Coverage

In the long term, we must ensure that all Americans have access to and are enrolled in an effective and efficient program for coverage. APHA believes that any proposals aimed at achieving universal coverage must be evaluated against the following criteria:

- **Costs of Health Care**. Will the proposal make health care more affordable for Americans? Will the proposal cause individuals to forego care because of insurmountable out-of-pocket expenses? The policy goal should be to reduce the growth of health care costs over time to make health care affordable.
- **Quality of Health Care.** Will the proposal reduce or eliminate disparities in health outcomes and care, curtail medical errors and otherwise ensure that Americans have access to the best medical care available? The evidence is clear that many in our nation, particularly racial and ethnic minorities, women, low-income Americans and those living in rural areas, receive a lower quality of health care with higher rates of illness, disability and premature death. The policy goal should be to improve the quality of care for all.
- **Access to Health Care**. Will the proposal cause some currently uninsured individuals to become insured or cause the number of uninsured and underinsured individuals to rise? Will it slow the erosion of employer-sponsored coverage by making such coverage more affordable to both employers and employees? Will the proposal negatively affect individuals who are currently and adequately insured through other mechanisms? The policy goal should be to ensure health care coverage for all.
- **Health Infrastructure**. Does the proposal address the weaknesses that stem from an eroding public health infrastructure? Does it address the growing work force shortages in health and public health practitioners, such as public health nurses, laboratory scientists and technicians, public health physicians and epidemiologists? There are tremendous health information and technology infrastructure needs. The policy goal should move the health and public health systems into the modern information age to allow for improved data-driven decision-making. It should also support efforts to rebuild the pipeline for health and public health workers.
- **Emphasis on Prevention.** How much does our health care system focus on the front end – preventing disease, injury and death – rather than treating the more costly symptoms on the back end? APHA supports policies that encourage evidence-based preventive health services. The policy goals should change the focus of the system towards prevention, which is cheaper and more cost-effective.

Mr. Chairman and members of the Committee, I thank you for this opportunity to submit this statement about one of the most important public health issues facing our nation. On behalf of the American Public Health Association, I look forward to working with you to ensure universal health care coverage for all Americans.

Susan R. Erzen
162 Covey Run Lane
Sequim, Washington 98382
March 20, 2007

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-203
Dirksen Senate Office Bldg,
Washington, DC 20510-6200b

Dear Honorable Senators of the US Senate Committee on Finance:

I support universal healthcare and a single payer system for financing it. I have participated in a local League of Women Voters Study group for the past 4 years and have followed the Citizens Working Group meetings on healthcare.

We are in a healthcare crisis. Over 46 million Americans are uninsured and at least that many are underinsured. In 2004, Elizabeth Warren of Harvard Law School published a study showing that 50% of all personal bankruptcies followed a medical crisis. And of those people filing personal bankruptcy, 75% had health insurance ("Sick and Broke", Elizabeth Warren, Miami Herald, 2/12/2005). Family insurance premiums in the United States are averaging more than $9,500 per annum. (Kaiser Family Foundation, 2005) Insurance is tied to employment in the USA. If you lose your job, you lose your insurance. Health insurance should be portable and lifelong. The U.S. is the only developed country that does not offer universal health coverage to its residents. Plus the USA has higher infant mortality and lower life expectancy rates than the other developed countries with universal coverage. (United Nations UNDP Human Development Report, 9/7/05)

I'm sure you are aware of those statistics and many more so I will not continue to list the problems Americans face to pay for healthcare and to find healthcare AND the fears Americans live with daily that they will not be able to afford medical care.

Physicians for a National Healthcare Program (PNHP) maintains that under a "Medicare for All" plan, the U.S. could save almost $300 billion in total health care costs while providing universal coverage for all. (www.pnhp.org) In 2004, total health care spending accounted for 15.3% of the United States GDP. The average for other industrialized OEDC (Organization for Economic Cooperation and Development) countries was 8.9%. (www.oedc.org)

Health care should be a right of all those living in the USA, not a commodity that is distributed and sold to those who can afford it and leaving those who cannot afford it without any health care coverage. The Citizen's Healthcare Working Group made its final recommendations and noted that there is "***remarkable consensus among Americans for public policy that ensures all Americans, regardless of their financial resources or health status, have affordable health care coverage***"

I support a single payer system to provide healthcare for everyone. That will take healthcare decisions out of the hands of private insurance companies. It will mean expanding medicare to

all citizens. As noted in the final recommendations of the CRWG : Perhaps the most challenging component of the Working Group's strategy is Recommendation 4: **Defining the core benefits and services that will be assured to all Americans.** But the CRWG also found a clear willingness amongst Americans to pay a fair share, to try to do a better job of taking care of themselves, and to accept limits on coverage if based on good medical evidence.

I urge you to stop letting insurance companies and pharmaceutical companies make our health care decisions. We elect our senators and representatives to make the difficult decisions that meet the needs of our citizens.

I ask you to step up to the plate and make the difficult decisions to realize affordable healthcare for everyone.

Respectfully,

Susan R. Erzen

To: The Honorable Max Baucus
Chairman
U.S. Senate on Finance
219 Dirksen Senate Office Building
Washington, DC 20210-6200

From: The attached 15 pages including this letter contain signatures from 289 Attendees at 2007 South Florida Pride Fest 3/10 and 3/11 Fort Lauderdale*

Collected by: Dr. Tina Pearl

Boca Raton, FL 33434

U.S. Senate Committee on Finance Congressional Hearing, March 14, 2007

RE: CITIZENS' HEALTH CARE WORKING GROUP RECOMMENDATIONS

Dear Senator Baucus:

On behalf of the Gay, Lesbian, Bisexual and Transgender community of South Florida, in association with the Lesbian Visibility Committee of the City of West Hollywood, CA, we the undersigned are writing to provide comment on the Citizen's Health Care Working Groups' (hereinafter referred to as "CHCWG") Recommendations as published in September 2006.

First and foremost, I want to commend the CHCWG for their time and effort in working to change the most critical problem facing our nation today – 64.7 million uninsured Americans. We agree with the Values & Principles as articulated, particularly that health and health care are fundamental to the well-being of the American people and that *all* Americans should have access to, at a minimum, a set of core health care services.

Concurrent with the first Recommendation, we believe that public policy should be enacted to make health care coverage and access available to *all* Americans.

Additionally, we agree that no individual in America should be impoverished by health care costs. The CHCWG recommends that an individual high deductible be mandated as the means to protect people from financial ruin as a result of these high health care costs. However, we cannot support this recommendation for the following reasons: Many individuals and families within the GLBT community have no disposable income. That said, if the government, whether federal, state or local, pays for the cost of the premium, the individual/ family remains responsible for the deductible, which represents a significant economic barrier. These individuals, already wary of a health care system that consistently discriminates against them and their chosen partners, will continue to avoid seeking necessary and preventative health care because of their financial concerns. They will continue to stretch their medications or deny the existence of illness. They will continue to enter hospital emergency rooms at a more critical and

more expensive point of care thus increasing the monies necessary to spend to treat them and at a cost that could have

been significantly lower. This line of thinking is actually more counterproductive and is counter-intuitive to its proposed goal and, consequently, does nothing more than make an already bad situation worse.

The CHCWG also recommends that the federal government should develop and expand the community-based network of health care providers as a way of providing care for underserved populations. While this would provide most local residents a source of coordinated health care, it would not guarantee that the health care needs of lesbian individuals would be met. At present, individuals and families within the GLBT community face discrimination on many levels within the health care system: from the inability to be insured under a partner's benefits package to the exclusion of the word "partner" on medical intake forms. If the health care system began to emphasize a community-based response as a solution, the ideals of a particular community would begin to penetrate the health care system to a further extent. In a community where anti-homosexual views are prevalent, therefore, a lesbian individual may not have equitable access to health care. We agree that we must address issues in the current delivery system for health care, but the recommendation to enhance the community-based health care system may only succeed in further disenfranchisement of an already underserved population.

Finally, with respect to the final three Recommendations: (a) that core benefits be defined; (b) that the quality and efficiency of the health care system be improved; and (c) that end-of-life services be fundamentally re-structured, we emphatically state that that the inclusion of GLBT-specific issues in all of these Recommendations is imperative. In prioritizing the medical conditions and treatments to be included in the core benefit definition, for example, the difference between the common medical conditions of heterosexual and homosexual women must be recognized as there are indeed some differences. Similarly GLBT people face a multitude of challenges in end-of-life care that are specific to the GLBT and community. Many hospitals, for example, will not allow partners to visit or make important health decisions because they are not recognized as a family member. It is essential that these issues remain in the forefront of the discussion if improved health care for *all* Americans is to be achieved. Anything less would be blatantly discriminatory and throw us backward in the progress already made in embracing who we are and exercising our civil rights in this country.

We the undersigned and as attached support and respect your efforts to change the face of healthcare on America but insist that the CHCWG and you consider the personal issues of taxpaying GLBT Americans in your final review and recommendations.

Thank you for your time and attention to this matter.

* The signatories to the above statement have been retained in the Committee files.

To: The Honorable Max Baucus
Chairman
U.S. Senate on Finance
219 Dirksen Senate Office Building
Washington, DC 20210-6200

U.S. Senate Committee on Finance Congressional Hearing, March 14, 2007

RE: CITIZENS' HEALTH CARE WORKING GROUP RECOMMENDATIONS

Dear Senator Baucus:

On behalf of the Lesbian Visibility Committee of the City of West Hollywood, CA, I am writing to provide comment on the Citizen's Health Care Working Groups' (hereinafter referred to as "CHCWG") Recommendations as published in September 2006.

I have read the Recommendations and believe that as a participant in this nation's health care system, I must bring another viewpoint to this discussion.

First and foremost, I want to commend the CHCWG for their time and effort in working to change the most critical problem facing our nation today – 64.7 million uninsured Americans. I agree with the Values & Principles as articulated, particularly that health and health care are fundamental to the well-being of the American people and that *all* Americans should have access to, at a minimum, a set of core health care services.

Concurrent with the first Recommendation, I believe that public policy should be enacted to make health care coverage and access available to *all* Americans.

Additionally, I agree that no individual in America should be impoverished by health care costs. The CHCWG recommends that an individual high deductible be mandated as the means to protect people from financial ruin as a result of these high health care costs. However, I cannot support this recommendation for the following reasons: Many individuals and families within the lesbian community have no disposable income. That said, if the government, whether federal, state or local, pays for the cost of the premium, the individual/ family remains responsible for the deductible, which represents a significant economic barrier. These individuals, already wary of a health care system that consistently discriminates against them and their chosen partners, will continue to avoid seeking necessary and preventative health care because of their financial concerns. They will continue to stretch their medications or deny the existence of illness. They will continue to enter hospital emergency rooms at a more critical and more expensive point of care thus increasing the monies necessary to spend to treat them and at a cost that could have

been significantly lower. This line of thinking is actually more counterproductive and is counter-intuitive to its proposed goal and, consequently, does nothing more than make an already bad situation worse.

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Finally, with respect to the final three Recommendations: (a) that core benefits be defined; (b) that the quality and efficiency of the health care system be improved; and (c) that end-of-life services be fundamentally re-structured, I emphatically state that that the inclusion of lesbian-specific issues in all of these Recommendations is imperative. In prioritizing the medical conditions and treatments to be included in the core benefit definition, for example, the difference between the common medical conditions of heterosexual and homosexual women must be recognized as there are indeed some differences. Similarly, lesbians face a multitude of challenges in end-of-life care that are specific to the lesbian community. Many hospitals, for example, will not allow partners to visit or make important health decisions because they are not recognized as a family member. It is essential that these issues remain in the forefront of the discussion if improved health care for *all* Americans is to be achieved. Anything less would be blatantly discriminatory and throw us backward in the progress already made in embracing who we are and exercising our civil rights in this country.

Thank you for your time and attention.

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* The signatories to the above statement have been retained in the Committee files.

"Everybody In — Nobody Out!"

Health Care for All/NJ

84 Jefferson St. #2-C Hoboken, NJ 07030

Phone: 201-533-0435 Fax: 201-533-0437 E-mail: hcfanj@att.net URL: www.hcfanj.org

March 15, 2007

Senate Committee on Finance
Attn: Editorial and Document Section
Room SD-203
Dirksen Senate Office Building
Washington, DC 20510-6200b

Re: 3-14-07 Hearing:
Charting a Course for Health Reform: Moving Toward Universal Coverage

As you may know, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (PL 108-173, hereinafter "MMA") established the Citizens Health Care Working Group (CHCWG) to ascertain public opinion and to make recommendations based on its findings. The recommendations were submitted to the president and to your committee and four others (Senate HELP, House Ways & Means, House Energy & Commerce, and House Education & the Workforce). 45 days after receiving the CHCWG's recommendations, the President was to issue his report and recommendations and deliver them to the five committees. Each committee was to hold "at least one hearing" on the recommendations within 45 days of receiving the president's recommendations.

Although it is nearly 6 months after issuance of the CHCWG's report, the President has not yet sent Congress his report and recommendations, despite the statutory timetable. As you will note below, this is but the latest governmental failure to observe the MMA's intent. Be that as it may, your hearing on this subject is most welcome, and we thank you for the opportunity to present our views for inclusion in the Senate Finance Committee's record on this pressing issue.

We also thank you for posting on your Web site the testimony of the four individuals who appeared before you in yesterday's hearing. They all agreed that your attention to the challenge of universal health care coverage is "important and long overdue" (James J. Mongan, MD), that "the need for national health reform becomes stronger every day" (Stuart Altman, PhD), that there is "a growing sub-class of Americans without access to the best American medicine" (John Shiels), and "[d]oing nothing to address a failing health care system will surely cost us more tomorrow than acting today" (Richard G. Frank).

The same considerations were obvious to Congress when it enacted the MMA. It hoped that the CHCWG would help settle controversy on how best to reform health care by ascertaining what the American people desire. It established a rigid timetable for hearings and community meetings, for Interim and Final Recommendations with a 90-day public comment in between them, and as previously noted for presidential recommendations and congressional hearings. We

responded to the opportunity afforded by the period for public comment on the CHCWG's Interim Recommendations, and sent the CHCWG our reaction, which is attached herewith in its entirety.

As Mr. Altman noted in his testimony, "[i]n survey after survey, the vast majority of Americans believe we should have a national system to protect all of us against the high cost of health care." For many years, polls have revealed that between two-thirds and three-quarters of respondents favored establishing a national health insurance program. This is the "elephant in the living room" that both our political leaders and their creation, the CHCWG, are loath to acknowledge.

It is interesting that CHCWG Vice-Chair Richard G. Frank (or was it CHCWG Chair Patricia A. Maryland? –the document's cover sheet and its second page differ) alleges that his/her testimony "reports on what we learned" from "engag[ing] the public in a nationwide discussion."

From the slanting of the questions asked of its community meetings' attendees to its failure to accurately represent its polling results, the CHCWG seemed bound and determined to avoid recommending to Congress and the President "ways to improve and strengthen the health care system ***based on the information and preferences expressed at the community meeting.***" (emphasis ours). To allay any doubts that this directive (PL 108-173, Sec. 1014(h)(4)(d)) was ignored, we suggest examination of Appendix B (posted on line at http://www.citizenshealthcare.gov/recommendations/dialogue.php). What's more, the Group didn't adopt the suggestions in the attached comments that might have helped it to better reflect its true findings.

It is our hope that your committee will continue to conduct hearing on this vital subject and will ultimately develop legislation that will — at long last — establish a national health program of the sort that Americans want and deserve.

Respectfully,

John Glasel
Secretary, Health Care for All/NJ

Enc.

Comments on Interim (6/1/06) Recommendations of the Citizens' Health Care Working Group

Thanks to the members and staff of the Citizens' Health Care Working Group for your diligent and thorough compilation of the hopes and desires of thousands of Americans from coast to coast. And thanks, too, to the members of the United States Congress who in their wisdom commissioned this exhaustive survey of their constituents. As long-time advocates for reforming our nation's health care system, this is the first time we can recall anyone other than professional pollsters surveying public opinion on the subject.

We fear, however, that these Interim Recommendations do not fully satisfy their mandate — to tell Congress what the people want. This can be partly attributed to some of the questions mandated by the legislation.

The Congressionally-Mandated Questions

The very first mandated question, "What health care benefits and services should be provided?" caused several difficulties. It implied that less than comprehensive benefits might be acceptable, and it raised the corollary question: who is to decide what benefits will be available?

The second and third congressional questions, "How does the American public want health care delivered?" and "How should health care coverage be financed?" were more open-ended, less controversial and yielded some valuable insights into public opinion.

But Congress' fourth question, about what "trade-offs" would be acceptable, gives credence to the suggestion that some "inside-the-Beltway" people may have lost touch with the American public (more on this later).

Interim Recommendation 1

Congress' first question led the Working Group to pose many questions in terms of "core benefits" or "a defined level of services." The CHCWG neatly finessed the difficulty that many participants had with that formulation[1] by asking whether they would want such "core" benefits to apply to everyone or merely to certain groups. Naturally, most respondents chose the more egalitarian option, so in addition to reflecting that choice, the CHCWG's first Interim Recommendation advocates "core health care services," a concept that derived only from the question, not the responses.

Interim Recommendation 2

The second Interim Recommendation artfully deals with the corollary question of who decides what benefits and services will be provided. In Appendices B and C, we learn that both on-line respondents and Community Meeting attendees preferred that consumers and medical professionals should make such decisions (with employers and insurance companies dead last at 0.8% and 0.5%,[2] or at 3.0 and 2.1 on a scale of 1 to 10,[3] respectively). But search as we may, we could find no question asking whether the benefits should be determined by "an independent, non-partisan public-private group." It's interesting that the Working Group didn't suggest that it might be not-for-profit! This recommendation seems to have emanated elsewhere than from survey participants.

Interim Recommendation 3

The third Interim Recommendation is that the new system should "guarantee financial protection against very high health care costs." But more than one-third of the survey's subjects — 34.1% of on-line respondents[4] and 33.9% of Community Meeting attendees[5] —thought that the system should pay for everyday health costs.

Everyone can agree with this Interim Recommendation's statement that "[n]o one in America should be impoverished by health care costs," although ensuring "[f]inancial protection for low income individuals and families" was low among Community Meeting attendees' priorities.[6] While not discussed by survey participants, such protection would require means-testing, which would entail considerable cost.

It is therefore surprising to see this Recommendation ignore both substantial minority opposition and the likelihood of higher costs by proposing "a national program (private or public)" that would probably resemble the high-deductible insurance scheme currently embodied in Medical Savings Accounts.

The "Dialogue with the American People" didn't indicate that it had asked Community Meeting attendees about high-deductible insurance coverage. But a considerable number of on-line respondents seem to have opposed this concept.[7] The third Interim Recommendation thus doesn't seem to reflect the opinions of the survey's participants.

Interim Recommendation 4

On the other hand, the fourth Interim Recommendation, to support integrated community health networks, was endorsed by respondents to the CHCWG's Internet Poll and the University Town Hall Meeting[8 9] as well as Community Meeting attendees,[10] even though your question didn't specifically ask about "integrated *public/private* networks." (Emphasis ours)

Interim Recommendation 5

The fifth Interim Recommendation proposes that the Federal government use "the resources of its public programs for advancing the development and implementation of strategies to improve quality and efficiency . . . ." Little support for this idea was expressed by attendees of the Community Meetings,[11] although most on-line respondents agreed or strongly agreed that health care providers should upgrade their computerized information systems.[12] Absent any discussion of the subject by survey participants, the fifth Interim Recommendation lets the "private" component of "public-private" off the hook! Where spending money might be necessary, the CHCWG seems to favor "corporate welfare."

Interim Recommendation 6

It is likely that most Americans agree with the Working Group's on-line respondents[13] (Community Meeting reports were anecdotal[14]) in wanting to restructure end-of-life health care, as the sixth Interim Recommendation proposes. However, no questions on this topic asked participants whether this should be accomplished through "public and private" payers or programs, as the Working Group recommends.

Support for Single System

The CHCWG's survey found overwhelming support for a single-payer, universal, government health insurance program.[15] [16] [17] [18] [19] This finding shouldn't surprise members of the Working Group, its staff, or the politicians by and for whom this effort has been commissioned, since independent polling[20] has long reported that as many as three-fourths of Americans favor such a system, even if it would require higher taxes.

Yet the phrasing of many of the CHCWG's questions seemed intended to lead to different conclusions.[21] [22] Recognizing this, many participants qualified their responses.[23] In particular, the fourth congressionally-mandated question, asking what "trade-offs in either benefits or financing" were acceptable, proved to be difficult for many.

"No Trade-Offs!"

As the CHCWG succinctly reported, "The single most common response to the question about trade-offs can be summarized as 'No trade-offs.'"[24] Although not expressly tabulated, it reported that "Individuals [at Community Meetings] voiced support for a fairly comprehensive benefit system"[25] and "were not comfortable with bare-bones benefit packages."[26]

The tabulation of Internet poll responses to "trade-off" questions presents a more nuanced insight. Combining the "agree and "strongly agree" responses, 65.4% favored "paying more in taxes to have basic health insurance for all"[27] with 60.5% approving "limiting coverage for certain end-of-life care services of questionable value in order to provide more at-home and comfort care for the dying.[28] Significantly, 62.1% of on-line respondents disagreed or strongly disagreed with the idea of "expanding federal programs to cover more people, but *provide fewer services to persons currently covered by those programs.*"[29] (Emphasis ours)

We believe that the relatively high number of "neutral" and "NA/NR" answers to these on-line questions indicated a high level of discomfort with the concept. This seems to show a disconnect between the well-insured elected officials who suggested "trade-offs" and those who will receive and/or provide health care under whatever system this effort may help to shape. We are reminded of a recent reaction to Congress' failure to increase the minimum wage: "[Set] representative's salaries at the minimum wage. If it's good enough for the rest of the country, it's good enough for Congress.[30]

Meetings' Preferences Should Be Reflected

To fairly report public sentiment to the President and Congress, you must acknowledge "the elephant in the living room," participants' support for a single-payer system, discussed above.[31] Whether or not the Working Group's members favor this idea, its Interim Recommendations should reflect this finding.

In its charge to the CHCWG, Congress ordered preparation of "an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system *based on the information and preferences expressed at the community meetings.*"[32] (Emphasis ours) Since support among Community Meeting attendees for a

single system was so overwhelming, it would be appropriate to list it first among the Interim Recommendations.

Tweak the Recommendations

It would be advisable to "tweak" the Interim Recommendations to satisfy Congress' directive that they reflect public sentiment as revealed at the Community Meetings. We suggest the following (using the existing numbers, even though we hope that a new first recommendation will be inserted):

Interim Recommendation 1: Delete "a set of core" before "health services," in the first explanatory paragraph.

Interim Recommendation 2: Delete "core" from title; delete "public-private" from first explanatory paragraph.

Interim Recommendation 3: Delete altogether, since participants' support was ambiguous, at best.

Interim Recommendation 4: Delete "public/private from first paragraph, and "public-private" from second bulleted point.

Interim Recommendation 5: If possible, urge that private providers should also be engaged in upgrading quality and efficiency.

Interim Recommendation 6: Delete "Public and Private" from the first two bulleted points.

We hope that the foregoing suggestions will be helpful to you in furthering the progress of this important project. Again, thank you for your fine work.

---

[1] *Dialogue with the American People,* p.8: "[S]ome participants indicated that it was hard to make a choice between the answers without knowing *who* was providing the coverage, or what would be covered."

[2] *Appendix B,* p. 3, weighted average of responses from five Community Meetings where question was "Who ought to decide what is in a basic benefits package? (SELECT ONE)"

[3] Appendix B, p. 3: average of responses from 15 Community Meetings where question was "On a scale of 1 (no input) to 10 (exclusive input), how much input should each of the following have in deciding what is in a basic benefit package?"

[4] *Appendix C,* p. 1, question #2.

[5] *Appendix B,* p. 2, column 2

[6] *Appendix B,* p. 7: In answering the question "If you believe it is important to ensure access to affordable, high quality health care coverage for all Americans, which is most important to you?" meeting participants ranked the option to "Expand State Medicaid, SCHIP, etc." (all low-income programs) quite low.

[7] *Appendix C,* p. 5: 43.5% of on-line respondents disagreed or strongly disagreed with option #11 b, "Paying a higher deductible in your insurance for more choice in doctors and hospitals." (More than 20% declined to express an opinion on this subject.)

[8] *Dialogue with the American People,* p. 41: ". . . consistently ranked in the top four choices at the community meeting locations and in the Internet poll."

[9] *Dialogue with the American People,* p. 42, Figure 9: The largest number of participants agreed or strongly agreed with the option, "Expand neighborhood health clinics"; see also *Appendix C,* p. 9, option #12 f.

[10] *Appendix B,* p. 7: "Expand Neighborhood Health Clinics" was ranked 2nd or 3rd among proposals to ensure health care access at the 19 meetings where the question was asked in this way.

[11] *Appendix B,* p. 6: "Develop Health Information Technology" ranked last or very low priority among options suggested to Community Meeting attendees.

[12] *Appendix C,* p. 4: 37.5% agreed and 34.5% strongly agreed with option #9 i., "Doctors, Hospitals and other health care providers should invest more in computerized information systems to monitor and improve health care quality, reduce errors, and improve administrative efficiencies."

[13] *Appendix C,* p. 5: 60.5% of on-line respondents agreed or strongly agreed with option #11 e, "Limiting coverage for certain end-of-life care services of questionable value in order to provide more at-home and comfort care for the dying."

[14] *Dialogue with the American People,* p. 32: "Support also existed for limiting expensive yet 'futile' end-of-life care and instead providing palliative care."

[15] *Appendix B,* p. 7, column 8: at 25 of 29 Community Meetings "Create a National Health Program" was the most heavily favored answer to the question, "If you believe it is important to ensure access to affordable, high quality health care coverage and services for all Americans which [is most important to you/of these proposals would you suggest for doing this]?"

[16] *Appendix C,* p. 6: 72.2% of on-line respondents either "agreed" or "strongly agreed" with option #12 g, "Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance." Conversely, the highest number of on-line respondents, 61%, either "disagreed" or "strongly disagreed" with option #12 c, "Rely on free-market competition among doctors, hospitals, other health care providers and insurance companies, rather than having government define benefits and set prices."

[17] *Dialogue with the American People,* pp. 4 and 41: "When asked to evaluate different proposals for ensuring access to affordable high quality health care coverage for all Americans, individuals at all but four meetings ranked *'Create a national health insurance program, financed by taxpayers, in which all Americans would get their insurance'* the highest."

[18] *Dialogue with the American People,* p. 42: 78% of respondents at the University Town Hall Meeting agreed or strongly agreed with the single payer option (as formulated in option #12g — see note 16, above).

[19] *Dialogue with the American People,* p. 30: "A commonly expressed view was that a simpler system would result in lower administrative costs. Participants believed that a more straightforward health care system would reduce administrative costs by eliminating duplication of services. At a number of meetings across the country, many individuals advocated a single payer system to eliminate the middleman, possibly one structured like Medicare or similar to the public school system. Under this type of system, everyone would pay taxes to support the system, even though, as with education, they might not use the services. Participants advocating the single payer concept said it would be the most efficient way to organize health care."

[20] *Dialogue with the American People,* p. 38: Four national surveys conducted from 2003 to 2005 found that many (up to 75% of) Americans would support guaranteeing coverage to all, even if it meant raising taxes.

[21] *Dialogue with the American People,* p. 22: "Others objected to the way the question was worded since they said it assumed implicitly that a national health care system would not exist."

[22] *Dialogue with the American People,* p. 23: "As with the previous question, some meeting participants expressed frustration with the way the question was worded and refused to answer. These individuals told the Working Group that they felt the questions implied continuation of the current delivery system. If a universal, possible single-payer system were implemented, their argument went, these questions would be irrelevant."

[23] *Dialogue with the American People*, p. 26: "Meeting participants who supported comprehensive reform through some type of national plan told the Working Group that, *in the absence of a national plan*, employers would need to be responsible, with tax breaks provided to assist small business." (Emphasis ours) — remember that these participants were part of an overwhelming majority favoring a single-payer system, as cited in notes 15, 16, 17, 18, & 19)

[24] *Dialogue with the American People*. pp. 10, 34.

[25] *Dialogue with the American People*. p. 10.

[26] Idem.

[27] *Appendix C*, p. 5, option #11 c.

[28] *Ibid.* option #11 e.

[29] *Ibid.* option #11 d.

[30] Henry Woronicz, letter to *The New York Times*, June 24, 2006, p. A14.

[31] See notes 15, 16, 17, 18, & 19, above, and referencing text.

[32] *Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)*: Sec. 1014 (h) (4) (D).

Testimony for the

United State Senate
Committee on Finance

Regarding

Charting a Course for Health Care Reform: Moving Towards Universal Coverage

Submitted by

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National Association of Health Underwriters

America's Benefits Specialists

March 26, 2007

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents and brokers, representing more than 20,000 health insurance producers and employee benefit specialists nationally. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage.

Because our membership is so invested in promoting access to private-sector solutions for health, financial and retirement security for all Americans, we held a teleconference for chapter leaders, as well as a public meeting at our annual convention in San Francisco in June of 2006 to discuss the Citizen's Health Care Working's recommendations. Based on those meetings, additional thoughts sent to us by our membership and our association's own policy statements, I offer the following comments to the Senate Committee on Finance as you consider the Working Group' s proposals:

Recommendation 1: Guarantee financial protection against very high health care costs.

NAHU agrees that financial protection against very high health care costs is critical, but we feel any solution to this problem should work within the existing private health insurance market framework. One way to address unhealthy risks in small-employer groups is through small-employer reinsurance pools.

In a reinsurance pool, when a carrier initially underwrites a case, it cedes unhealthy risks to a state reinsurance pool. This is transparent to the covered individual. If claims exceed a certain level, the reinsurance pool reimburses the carrier for its losses. Reinsurance pools are funded by premiums paid by participating carriers.

Reinsurance pool success has been marginal in terms of their ability to produce cost savings in a given market, largely due to two reasons. First, all but one pool is voluntary.

So some, but not all, carriers in a market participate in the pool. The largest carriers have a lesser need for reinsurance at the same levels, and have their own sources for excess losses. The pools have been small, and the cost of reinsurance passed back to consumers has been greater than it would have been with more participation by more and larger carriers with more risks to cede.

Making reinsurance pools mandatory is not the answer. However, enticing all players in a market to participate in the pool with meaningful federal subsidies would be a different matter. If all carriers participate in the pool, more unhealthy risks are removed from the regular pool, and the cost of coverage goes down. If federal subsidies paid the cost of reinsurance, the reinsurance cost would never trickle back to the cost of coverage.

Some have suggested that reinsurance coverage only be provided to participants in government-sponsored pools. This would create an unlevel playing field, waste unnecessary time while the pools are developed, and create unnecessary bureaucracy on an unproven entity. Any reinsurance subsidy considered should be universal across a market segment, such as all small groups, or not used at all. Otherwise, access to affordable coverage could ultimately be reduced, rather than increased.

In addition to addressing high-risk costs in the group insurance market, NAHU believes that any proposal should also include increased federal grant support for state high-risk health insurance pools. High-risk pools provide an important safety net for people with catastrophic medical conditions who do not have access to employer-based group health insurance, such as early retirees, self-employed individuals and employees of businesses that do not offer health insurance coverage.

In addition, in many states high-risk pools serve as the guaranteed-issue purchasing option for individuals who wish to exercise their federal group-to-individual health insurance portability rights as provided by the federal Health Insurance Portability and Accountability Act of 1996, or as a purchasing option for individuals who are eligible for the 65 percent federal health insurance tax credit provided by the Trade Adjustment Assistance Act of 2002.

The type of coverage available to risk pool members in most states mirrors what is generally available in the traditional private individual health insurance market in the state. Risk-pool consumers are charged more for coverage than the average individual market consumers, which is fair because pool members, by definition, are those who are considered to be medically uninsurable. However, state laws caps risk-pool rates at generally between 125-150 percent of the base individual market rate. High-risk pools are an extremely important market stabilizer for both the individual and small-group markets, and prevent the need to "game the system" to qualify for other sources of guaranteed coverage.

Recommendation 2: Support integrated community health networks.
NAHU agrees that federally-funded community health centers are important safety nets for uninsured and under-insured Americans, particularly in rural areas where access to

other care providers may be limited. We also feel that many private entities provide similar services to the same populations, and that increased public-private partnerships in the area of community health with broader public financial support would be very beneficial. In addition, we agree with your recommendation that "Better communication, both within the community and among communities is essential. The use of tools such as electronic health records is critical, as well."

Recommendation 3: Promote efforts to improve quality of care and efficiency. NAHU is highly supportive of efforts to improve the quality of health care that Americans receive, and also efforts to reduce waste and inefficiency when such care is being provided. We believe that health care delivery system inefficiencies have had a dramatic impact on the cost of medical care in this country, which has in turn limited access to health care for many Americans. Duplication of procedures and overuse of high-end procedures in situations where they add little value have driven up medical spending unnecessarily, and unnecessary medical treatments and prescriptions are costing the U.S. health care system billions of dollars each year.

The inconsistent focus on quality outcomes when providing treatment is another inefficiency impacting medical costs. Furthermore, preventable mistakes caused by providers of medical care also help account for rising costs. NAHU supports the use of electronic medical records to help unify the health care system, as well as pay-for-performance initiatives to positively impact care outcomes and reduce the number of medical errors. We also agree that increased level of medical care price transparency in the United States is essential. We would like to see these ideas implemented both with federally funded health programs such as Medicare, Medicaid, community health centers, TRICARE and the Veterans' Health Administration, and also voluntarily within the private sector.

Recommendation 4: Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided, so that people living with advanced incurable conditions have increased access to these services in the environment they choose.

NAHU agrees that individuals nearing the end of life and their families need support from the health care system to understand their options, make their choices about care delivery known, and have those choices honored. However, we feel that any recommendation made by your working group should also encourage Americans to privately plan for their future long-term care needs and include support for increased public incentives for the purchase of private long-term care insurance.

NAHU believes that consumers should be encouraged to select the long-term care policy of their choice based on complete, specific information. It is our view that premiums paid for tax-qualified long-term care insurance policies should be deductible directly from gross income for federal income tax purposes. Also, employers should be able to offer long-term care insurance policies to their employees under an IRS Section 125 cafeteria program.

Finally, the states, state departments of insurance and the private sector should undertake, in cooperation with the federal government, a program of education to inform the public about the risks of catastrophic long-term care costs, and the limited availability of government resources to pay for these costs. This is particularly important at the present time, considering the first year of the baby boom generation will turn 60 in 2006.

Recommendation 5: It should be public policy that all Americans have affordable health care.

NAHU urges Congressional action through private-market initiatives to provide Americans with access to affordable health care. But there is a difference between access to health care services and insurance benefits for such services. As a society, we have a responsibility to see that people receive the health care services they truly need. However, any attempt to provide Americans with universal access to health coverage should preserve the private health insurance market. Other countries have experimented with government-run health care systems, and this has only resulted in high-cost, lower-quality, rationed care. Americans need to be able to access a competitive health insurance marketplace with a wide range of health plan choices.

The public policy components that NAHU believes would be necessary to ensure that all Americans have access to affordable, privately marketed health insurance coverage include:

- The availability of advanceable and refundable federal health insurance tax credits for low-income individuals. This credit should be available to purchase either individual market coverage or coverage through the employer-based health insurance system.
- Expansion of access to consumer-directed health insurance alternatives.
- The development of creative ways to insure high-risk individuals, such as the use of group-market reinsurance pools. This will ensure that coverage for the majority of individuals who are healthy remains affordable.
- The availability of a health care safety net for the lowest-income segments of our population that utilizes the private market wherever possible to provide individuals with high-quality medical options.
- The availability of continued federal funding for individual market high-risk health insurance pools, which provide an important safety net for people with catastrophic medical conditions who do not have access to other health insurance coverage.

NAHU also feels that the working group and Congress should look at state programs with proven track records for success. States often have excellent ideas of their own for increasing access to health care. One of the best is from the state of Oregon. Its innovative program provides subsidies from 50 to 95 percent of the cost of private health insurance coverage through the Family Health Insurance Program. The cost is paid through state appropriations. Coverage can be provided either through an individual or group plan. The statistics on the program are very interesting, and it has been a success. The program has a waiting list due to state budget constraints, which would be alleviated with a federal grant.

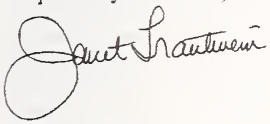
Other states could be encouraged to undertake such a program. If a federal tax credit with broad eligibility for low-income individuals passed, states could supplement federal tax dollars with state subsidies, increasing affordability of coverage and reducing the number of uninsured. Such grants could also be used to subsidize high-risk health insurance premiums for low-income individuals, as is already being done by several states. Grants could be directed at those who need help most, depending on the conditions in individual states.

Recommendation 6: Define a 'core' benefit package for all Americans.
NAHU has grave concerns about the development of a "core benefits package" for all Americans, and we oppose the federal government getting into the health benefit mandating business. Benefit mandates add to the cost of health insurance, as has been demonstrated repeatedly at the state level. There are now over 1,800 benefit mandates in existence, which various studies have shown add as much as 25 percent to the cost of insurance premiums.

In addition, the development of a mandatory package of benefits would limit health plan innovation, both in the area of product design and also in efforts to curb costs. NAHU finds it much preferable to leave health plan design up to market forces so that individuals and businesses are able to choose products that best fit their specific needs.

We look forward to working with the Committee on Finance as you consider the Working Group's recommendations and endeavor to improve our nation's health care delivery system. If you have any questions, or if our association could be of any further assistance, please do not hesitate to either contact me at (703) 276-3806 or jtrautwein@nahu.org, or our vice president of policy and state affairs, Jessica Waltman, at 610-972-2404 or jwaltman@nahu.org.

Respectfully submitted,



Janet Trautwein
Executive Vice President and CEO

The National Coalition of Mental Health Professionals & Consumers, Inc.

Working To Inform America About Real Mental Health Care
Fighting To Protect Quality Care, Patient Choice, Privacy And Decision-Making Power

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March 27, 2007

TO: The U.S. Senate Committee of Finance

RE: Hearing – 3/14/07
Charting a Course for Health Care Reform:
Moving
Toward Universal Coverage

We request that you include our views in the hearing record. These are submitted in the form of a copy of our original Official Comments to the Citizens Health Care Working Group and are attached.

Thank you.

The Officers and Board of Directors,
on behalf of the Members of The National Coalition of Mental Health Professionals and Consumers, Inc.

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NCMHPC Official Comments on Interim Rec. CHCWG 8-26-06FINAL.doc

August 26, 2006

Citizens Health Care Working Group
7201 Wisconsin Avenue
Bethesda, MD 20814
CitizensHealth@ahrq.gov

Re: The National Coalition of Mental Health Professionals and Consumers - Comments on the Interim Recommendations of the Working Group

Dear Members of the Working Group:

We, the people in America, owe much thanks to the members and staff of the Citizens' Health Care Working Group for the thorough and careful compilation of the hopes and ideas of desperately-needed change from Americans from coast to coast. Your openness to internal debate and innovation has added immeasurably to the resulting data, and can lead to solid ideas for reform legislation in your final recommendations to Congress and to the President.

We are also grateful to the wisdom of those men and women of the United States Congress who legislatively mandated the commissioning of this historic, encouragement of exhaustive input from their constituents. The National Coalition of Mental Health Professionals & Consumers is composed of long-time advocates for reforming our nation's health care system - this the first time we know of such surveying of public opinion, with a genuine welcoming of the people's extensive, in detail, input on making sense of health care in our nation. and ways that the nation might actually make health care work for all Americans.

The National Coalition of Mental Health Professionals & Consumers is a national grassroots organization of consumers, interdisciplinary mental health and substance abuse care professionals, and consumer advocates. We are an educational foundation and advocacy organization serving consumers and professionals, committed to the preservation of confidentiality, integrity, and quality care for all, through education, political and legal action to preserve and promote the highest standards of comprehensive care and health care privacy.

The National Coalition of Mental Health Professionals & Consumers works to preserve quality care and the consumer's rights to choice, personal privacy, and control over treatment decisions. We work in the fight for solid reform in the health care system to guarantee quality mental health and substance abuse care. We work through public and professional education, and through legal and legislative action, to replace managed care with a pro-patient, pro-quality, pro-consumer system that is affordable and accessible for all.

We address the ways in which managed care negatively impacts patients and professionals in mental health care and often increases distress, and promotes rather than abolishes stigma. We have been working for the past 14 years to promote a mentally healthy nation where those who suffer from mental and emotional disorders are treated fairly and humanely, and where admitting to treatment for mental and emotional distress is no longer stigmatized. America's political leadership has so far failed to address this very challenge.

Your work will hopefully accelerate the potential for change that we see as glimmers of hope in that national and state political leadership. We have been paying close attention to the work of the Citizens' Health Care Working Group, to your working process and to the input you have received. We have recognized from the outset the potential value of your effort, the import for solid and genuine reforms which would benefit all in our nation, as well as the potential misuses of your valuable work by powerful interests that are vested highly in only self-serving, profit-making changes.

We believe that the primary function of the Working Group, and the only one that will have any impact on the Executive and Legislative branches of government, will be the Recommendations that are required to be sent to the White House and the Congress, as the legislation mandates.

For this very purpose, the National Coalition is a National Partner in the Making Health Care Work for All Campaign, doing the organizing work needed for solidly impacting the recommendations of the Citizen's Health Care Working Group, with particular commitment to make sure that mental health and substance abuse care is not relegated to a low priority service by the Citizen's Health Care Working Group in its charge by Congress to make recommendations which lead to Presidential and Congressional legislative proposals by 2007.

The National Coalition wants to go on record as agreeing with the *Principles* for health care that the Working Group has concluded. We wholeheartedly agree with your statement comment about how important it is to "reconcile contrasting views about the role of the marketplace and government, of competition and planning, of individual and shared responsibility." We are pleased that your *Values and Principles Section* emphasizes the role of shared social responsibility both in paying for care and in consideration of health care costs. Most importantly, you state that you "do not believe that the most important barriers to achieving a heath care system that works for all are technical." We fully agree - the barriers are, most decidedly, political.

We fear, however, that these Interim Recommendations do not fully satisfy their mandate — to tell Congress what the people want. This can be partly attributed to some of the questions mandated by the legislation. Congress charged you to prepare recommendations on "health care coverage and ways to improve and strengthen the health care system based on the information and

preferences expressed at the community meetings." You have heard from 10s of thousands of the American public, from widely diverse regions and from many, many walks of life in this democratic and inclusive process.

Your report states: *"Across every venue we explored, we heard a common message: Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to provide access to appropriate, high-quality care without endangering individual or family financial security."* From the Interim report: http://www.citizenshealthcare.gov/recommendations/interim_recommendations.pdf

However, we believe that your Interim Recommendations, while so positive in many ways, do not accurately reflect two very important messages you received from the great majority of participants in the public process:

- *Over two-thirds support for the goal to" Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance."*
- *You received universal resistance to the "zero-sum" trade-off ideas* on which some of the questions posed were based, that is, *overwhelming opposition to the implication that greater access to health care might only be afforded and achieved by reducing benefits.*
- *You have heard unequivocally from the public that they do not want business as usual in health care to continue.*

Yet, these two themes are not reflected anywhere in your report - the Interim Recommendations don't follow the law's directive to reflect the opinions expressed by the public input which you so diligently mobilized, documented and tabulated.

We are deeply concerned that some members of Congress will select those portions of this report that support their own individual agendas, while ignoring the overriding message supporting an equitable, comprehensive, high-quality system for everyone.

It is our hope that the Final Recommendations will be revised so as to correct that flaw. We trust that your Final Recommendations will more effectively highlight the public support for an easy-to-navigate national health plan and public opposition to measures that seek to control costs by reducing access to categories of benefits.

All who participated in this process and have tracked the input made available by the Working Group see that the "common message" above represents the prevailing views of the participants. ***We want a universal, comprehensive, high-quality system that does not endanger financial security for anyone. The need for a long-term overall strategy to achieve health care for all, not***

just short-term steps, is critically important to achieve health system change. And, it is important to reinstate the goal of 2012, or earlier, as the deadline for achieving health care for all.

Our serious concern is that actual details of the report do not reflect this "common message" and the prevailing views, but, rather reflect the opinions of a select few, possibly from the Working Group, possibly from the current federal government administration. Proposals, based more on ideology than reality, do nothing to address America's present, and rapidly expanding, health care crisis.

The Working Group's key principle is that health care is a "shared social responsibility." The National Coalition is convinced that the principle of shared social responsibility both on cost and on access are the essential foundation for successful and sustainable reform.

To be truly successful, reforms must share responsibility among those who pay for health care - individuals, employers, and state, local and federal governments - to assure affordability for all. Successful reforms must encourage and facilitate commitments to genuine stewardship of the limited resources among those who provide care to maximize the value of every dollar spent on health care.

The principles of "shared social responsibility" rejects the market approach as the fundamental organizing principle of health care. So did online survey respondents with 62% disagreeing with the statement, "We all should be responsible for setting aside enough money to pay for most of our health care expenses." In view of this foundational principal of "shared social responsibility," the National Coalition offers a few succinct comments on the Working Group's six"Recommendations," as follows:

Recommendation #1
The central problem of affordability in health care must have the goals of:

- Remove financial barriers to health care - shared responsibility for financing care cannot mean high patient cost-sharing.
- Making premiums affordable by requiring high deductibles or high co-pays at point-of-service would create shallow insurance that Americans could not afford to use.
- The recommendation for a national program is also hampered by the statement that it should be public or private. It might combine both public and private elements.
- Medicare has won widespread support by combining private delivery of care with public coverage.
- The above points will then address the invaluable elimination of medical bankruptcy – clearly a problem unique to our nation.

Recommendation #2
The National Coalition strongly believes that there should be no modification of the Federally Qualified Health Center concept.

- We believe in expanding integrated community networks - providing high quality coordinated care to vulnerable populations through integrated community networks is certainly an essential goal..

- As the health care safety net is strengthened, preserve community control of the boards of federally qualified community health centers

- Paralleling the necessity of continuity of comprehensive care in mental health and substance abuse services, beginning with preventive services and early interventions, coordination has to be between ambulatory care and in-hospital care, between primary care and specialty care.

- The problems faced by providers in the current safety net stem from both under funding and obstacles to obtaining hospital and specialist care.

- A true integration would mean the gradual disappearance of a separate sector called "the safety net."

Recommendation #3
From the Working Group Interim Recommendations:

"Using federally-funded health programs such as Medicare, Medicaid, Community Health Centers, TRICARE, and the Veterans' Health Administration (VA), the federal government will promote:

- Integrated health care systems built around evidence-based best practices;
- Health information technologies and electronic medical record systems with special emphasis on their implementation in teaching hospitals and clinics where medical residents are trained and who work with underserved and uninsured populations;
- Reduction of fraud and waste in administration and clinical practice;
- Consumer-usable information about health care services that includes information on prices, cost-sharing, quality and efficiency, and benefits; and
- Health education, patient-provider communication, and patient-centered care, disease prevention, and health promotion."

These are all important and valid goals which are parts of promoting better quality and more efficient use of resources, with this caveat:

- As long as health care remains fragmented and there is no continuity of care working for people, these goals above cannot achieve what is needed and possible.

- Promotion work in these areas must be allow for patient choice, facilitate the continuity of care, and facilitate the coordination of health care.

Recommendation #4
The principles and concepts from these recommendations on palliative care, hospice care and other end-of-life services, must be fully applied to all people who suffer with the whole spectrum of chronic diseases.

Recommendation #5 - The most important goal – must be achieved by 2012:

"It should be public policy that all Americans have affordable health care."

The Interim Recommendations must be revised:

- to remain consistent and true to the *Principles* and the Value of "shared social responsibility" – the core value that "we're all in this together" - that these are all issues of what is needed to promote the common good.
- to not start regressing and relying on the concept of "financial assistance" to individuals in this recommendation - this concept invariably has promoted budget cutting of "safety net" programs.

The Working Group statement that "benefits that are sufficiently comprehensive to provide access to appropriate, high-quality care without endangering individual or family financial security" is soundly based on the belief that benefits that are broad in scope are indeed vital. Public online input clearly wanted broad, inclusive, comprehensive benefits, and rejected exclusion of types of care as a main tool to limit cost.

This recommendation also does not reflect the majority of public input, basically because it reverts to a reliance upon a market approach to containing costs. Emphasizing "consumer usable information on prices" rather than public policy tools, it ignores such valuable public policy tools as:

- ✓ slashing administrative costs by eliminating the complexity of thousands of different insurers and plans,
- ✓ capping the share of health insurance premiums that can be used for administration, marketing and profit, and,
- ✓ federal government negotiations to cut drug prices for Medicare and all Americans, which over 70% of on-line survey participants support.
- ✓ coupling cost controls with coverage expansion would make broad and deep coverage affordable now.

Recommendation on Financing Health Care That Works
Financing strategies must be linked to principles of fairness and efficiency:

- ***Efficiency in financing means reducing the paperwork shuffle, the administrative waste, the plethora of confusing and concealed prices.***
- ***Fairness means financing care in ways based on one's ability to pay, not one's health status*** - 47% of survey responses support income-linked payment standards for determining who should pay more for coverage.
- This emphasizes the importance of the Working Group's mention of the graduated income tax as a potential revenue source.
- Survey participants also reject making people pay more based on health behaviors or health status - 70% disagree with requiring people who use more health services to pay higher premiums.

Recommendation #6 - **The National Coalition wants to have greater discussions with the Working Group about what constitutes at an adequate mental health and substance abuse care benefit – as always, "the devil is in the details." The decades-long propaganda by the drug and insurance industries, the marketing of drastic rationing of mental health and substance abuse care services, and of the "great values of 'managed care' and 'quick fixes' by drugs" has profoundly distorted the thinking of the public and of elected officials about these very essential details, and has led to the further stigmatization of mental health and substance abuse conditions in America.**

"Define a 'core' benefit package for all Americans.

Establish an independent non-partisan private-public group to identify and update recommendations for what would be covered under high-cost protection and core benefits.

- *Members will be appointed through a process defined in law that includes citizens representing a broad spectrum of the population including, but not limited to, patients, providers, and payers, and staffed by experts.*
- *Identification of high cost and core benefits will be made through an independent, fair, transparent, and scientific process.*

The set of core health services will go across the continuum of care throughout the lifespan.

- *Health care encompasses wellness, preventive services, primary care, acute care, prescription drugs, patient education, treatment and management of health problems provided across a full range of inpatient and outpatient settings.*
    - *Health is defined to include physical, mental, and dental health.*

> *Core benefits will be specified by taking into account evidence-based science and expert consensus regarding the medical effectiveness of treatments. "(From http://www.citizenshealthcare.gov/recommendations/interim_recommendations.php#interimrecs)*

The delivery of truly medically unnecessary (as defined by the health care professions), of truly non-core benefits is not what makes American health care so unaffordable.

The cost problem in American health care results from three main sources:

- excessively high prices for care in the U.S.,
- administrative costs of highly fragmented private insurance, and,
- too many core services performed in clinical situations where they are of little to no benefit.

So-called "consumer directed" health care reforms will not work – we need a national system to provide health care for all. Shared social responsibility for covering the cost of health care also entails social responsibility for containing costs, including prices. Cutting prices cannot be left to individual patients' comparison shopping. This also is be a shared social responsibility, not a market-based, shopper's duty. So-called "consumer directed" health care reforms will not work – we need a national system to provide health care for all – this is what the American people keep calling for!

◆

Thank you for your careful reading of this Public Comment document from the National Coalition. We trust it will help inform your Final Recommendations.

Sincerely,

The Officers and Board of Directors,
on behalf the Members of the National Coalition
of Mental Health Professionals and Consumers, Inc.

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The power to end hunger.
RESULTS

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March 28, 2007

Senate Committee on Finance
Attn. Editorial and Document Section
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Washington, DC 20510-6200b

To Whom It May Concern:

RESULTS requests that this letter be submitted as testimony for inclusion to the hearing record from the Senate Finance Committee Hearing that occurred on March 14, 2007, at 10:00 a.m. in room 215 of the Dirksen Senate Office Building entitled, "Charting a Course for Health Care Reform: Moving Toward Universal Coverage."

RESULTS is a nonprofit grassroots advocacy organization, committed to creating the political will to end hunger and the worst aspects of poverty. We have volunteer groups in close to one hundred communities across the nation. RESULTS groups across the country participated in local Citizens' Health Care Working Group events and submitted testimony through the Working Group's website as a part of the Making Health Care Work for All Campaign. Whether from RESULTS activists or others, the Working Group heard the same message from the public in every venue:

> Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to ensure access to appropriate, high-quality care without endangering individual or family financial security.

We support the findings of the Working Group and, along with the Institute of Medicine and a host of other organizations, we believe that it is a moral and economic imperative to work towards healthcare for all by 2010. America spends more on health insurance per person than any industrialized nation in the world, and yet 47 million Americans lack health insurance. Of those, more than 9 million are children. Those with health insurance feel the cost of the uninsured, paying an average of $922 more per year in premiums due to the unpaid health care costs of the uninsured. By 2010, Families USA reports that the cost per person for coverage of the uninsured is expected to rise to $1,502. Employees with health insurance are seeing insurance premiums rising faster than their wages, and employers are increasingly not covering their employees as the cost continues to rise. We find it troubling but true that, according to the findings of the Citizens' Health Care Working Group, health care is projected to cost $11,000 by the year 2011, and we have gone from spending in 1960 five cents of every dollar earned on health care to

spending fifteen cents of every dollar earned on health care today. It is a troubling but true fact: the American health care system is in a moment of crisis.

We urge the committee to act in support of many of the Working Group's recommendations by pursuing two simultaneous "tracks": 1. strengthening our existing safety net by passing a strong reauthorization of the State Children's Health Insurance Program in the coming month which allocates significant new resources to expand the program and 2. pursue substantial health care reform that gets the United States to the goal of health care for all Americans as called for in the Working Group's report. In broad principle, we support Chairman Baucus' five broad principles of reform: universal coverage; sharing the financial burden by means of pooling arrangements; controlling costs; emphasizing preventative care; and sharing the responsibility of creating a new health care system.

We hope that you will consider this testimony as an additional reason to support the findings of the Citizens' Health Care Working Group and to work toward universal coverage and a healthier nation.

Sincerely,

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Senate Finance Committee Hearing

Charting a Course for Health Care Reform:Moving toward Universal Coverage

March 14,2007 at 10:00 am ,Rm 215 Dirksen Building

Submitted by Rebecca Elgie

Co-Director of The Tompkins County Health Care Task Force

115 The Commons

Ithaca, New York 14850-3738

Senate Finance Committee Hearing Testimony
March 14, 2007

Charting A Course for Health Care Reform: Moving Toward Universal Coverage

I became involved with this issue after I retired from teaching 4 years ago and now work full time on health care reform. I am co-director of the Tompkins County Health Care Task Force. Our organization seeks to educate, advocate and legislate in support for a Single Payer plan for all. I have looked at other proposals which have been recommended over the years and continue to be proposed at increasing rates both at the state and national level. With each incremental plan I become more convinced that a Single Payer, one risk pool plan which is publicly financed and privately delivered is the only answer.

The urgent need for such a plan was all too clear when the summer before last we walked close to 400 miles across the southern tier of New York state talking with people and holding rallies and forums. We built a network of agencies, groups, legislators and individuals who are concerned about this issue. As we walked we talked with farmers who did not have health insurance and were one accident away from losing their farm, with people working in social agencies who helped others try to enroll in programs such as Family Health Plus but who did not have health care for their own family because they earned just a little too much money to qualify and to others whose clients needed substance abuse treatment but their insurance would cover only a minimal number of visits which were not enough to make them well. We talked with medicaid recipients who could not find doctors and dentists who would take Medicaid patients and they ended up putting off visits until their health needs were so serious that they required emergency room treatment. We talked with doctors who could no longer stay in private practice because they could not afford the staff necessary to process the paperwork, others who spent much of their time on the phone trying to get approval for a procedure and who found it was cheaper to treat Medicaid patients pro bono because it was more expensive to try to get the reimbursement. We talked with a nurse who said that the bulk of her time was spent filling out paperwork and she no longer felt she was doing the nursing she was trained for. We even met a fellow who when he saw our sign saying Health Care for All told us to "go to Canada" , at first I thought he was being facetious but as we talked more it turned out that he lives in Canada and had hurt his foot and had been cared for in Canada by showing his health card, he was now on vacation and very happy with the care he received. Everywhere we went we heard heart wrenching stories from people who were suffering as a result of our current patchwork system.

This past summer and fall we returned to many of these communities and worked with groups which have formed to work on this topic and with political groups to raise the issue of Universal Health Care at candidates meetings and in private conversations and communications with candidates to raise this issue on the political radar screen. We have also been working with County and City Legislatures to encourage them to pass resolutions in support of a Single Payer Plan and have received very a positive response in part because city and county governments are going bankrupt due to health care expenses. In the 2007-08 New York State budget 27% of the budget is proposed to cover medicaid costs ($32.1 billion) and this excludes $16.6 billion in Medicaid

spending by local governments and other state agencies. All of these activities are geared to educate and to build political will in support of a systemic change.

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The first universal health care proposal was introduced in the assembly in 1915 but we now have 47 Million without insurance and many more who are underinsured despite the fact that we now spend $7,498 per capita on health care which is more than twice as much as any of the industrialized nations who cover everyone.

A number of legislators are recommending that we should extend our safety net programs such as SCHIP - State's Children Health Insurance Program. This approach will not lower the cost of health care but will increase the cost for government and the tax payers. Such programs force people to prove that they qualify ie deserve the service Enrolling is complex, re-enrolling is difficult and many applicants are lost during this process and care is sporadic. It is estimated that close to half the children who qualify are not enrolled because the system is so complex. Despite the increase in numbers receiving these programs the number of uninsured has remained the same because employers have been dropping coverage due to the high cost of providing health care for their employees. Employers cannot pay such high prices and also compete in the global market. The average cost of premiums according to a recent study is over $10,000 for a family plan. If we had a national health care plan where everyone was enrolled at birth in a comprehensive, one risk pool plan such as HR676 the John Conyers has proposed this would no longer be an issue.

Many say that we cannot afford such a plan, that it would raise taxes. In fact we are already paying 2/3 of our current health care system through our taxes. We are already paying for a national health insurance plan but we are not getting it. Other states have looked at the costs and the Lewin Group has done a cost analysis if a Single Payer plan in California. Sen Kuehl's Single payer plan passed in both the house and senate but was vetoed by the governor. The study affirms that we can create a fiscally sound, reliable insurance plan that covers all residents and controls health cost inflation. It shows that individuals, families, businesses will all save money. In this study it was predicted that the legislation would save California $343.6 billion in health care costs over the next 10 years, mainly by cutting administration costs and by using bulk purchases of drugs and medical equipment. In the first year the state would save about $8 billion by replacing the current system of multiple public and private insurers with a single insurance plan, saving $20 billion in administrative costs, buying prescription drugs and durable medical equipment in bulk, saving $5.2 billion and saving state and local governments about $900 million. Businesses would save about 16% and families making under $150,000 would save between $600 -$3,000. This plan covers medical, dental& vision care, prescription drug, emergency room services, surgical & recuperative care; orthodontia, mental health care & drug rehabilitation, immunization, emergency transportation, laboratory and diagnostic, adult day care, necessary translation & interpretation, chiropractic care, acupuncture, case management and skilled nursing care.. The consumer has the freedom to choose his or her own care providers which means that people will be free to change jobs, start a family, start a business, continue education or change residences and be secure in the knowledge that his or her relationships with trusted health care givers will be secure. (See attached Lewin Group analysis summary) National studies produce similar projected savings. (See attached Healthcare-now cost analysis sheets)

This change would require realigning on the part of Health Insurance companies with some of their workers going into other areas of insurance and others being retrained for other types of work. Some proposals allocate money for retraining. In many cases this might still be in the health care industry. It is similar to what happens in other industries such as the automotive industry which has had to downsize or relocate because of the current high health care costs. Private insurers have had a chance to address the situation but they have been ineffective in expanding coverage and affordability and have been the greatest cause of the expanding inefficiency of our system. The private insurance companies have avoided its purpose of pooling risk by skimming of the healthy sector of our population and leaving the risk of the high-cost individuals with us the taxpayers. It is clear that a market-based plan does not work for health care - Economist Paul Krugman has made that clear in the many articles he has written on this subject. We can't treat health care like a commodity where make a profit is the driving force. It is clear that private insurers' primary product is not insurance but administrative services and this has contributed significantly to the waste in health care spending. It is time for our public officials to pass legislation for the program we need, a Single Payer plan for all United States residents.

I have followed the work of the Citizens' Health Care Working Group and participated in the discussions and offered input. We need to liste to the public response which clearly says that "Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to ensure access to appropriate, high-quality care without endangering individual or family financial security" . I appreciate the work that went into this group and the fact that hearings were held around the country. At the hearing in New York City 97% of the Community expressed that they felt Affordable Health Care should be public policy and 97% said they believed that Health Care should cover a level of benefits for ALL. Your constituents have spoken loud and clear - please head their call for help.

I feel confident that if you look at the financing of such a system the only way to provide the above is with a publicly financed system where everyone is in the one risk pool and individuals have their own choice of physicians and facilities without premiums, out-of-pocket expenses or fear of denials of insurance or losing their insurance when they change jobs or move to a new location. We already have a model of such a system in Medicare we now have to ensure that everyone is guaranteed health care as a right not a privilege.

Thank you for addressing this important issue.

Rebecca Elgie

Sincerely,

Rebecca Elgie
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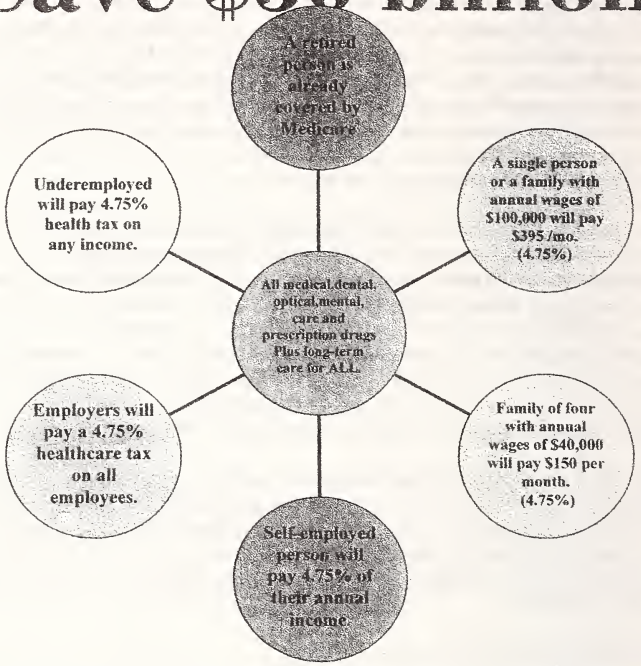
Ithaca, New York 14850-3738
607-272-0621

SINGLE PAYER -- The United States National Health Insurance Act, H.R. 676, will cost you less.

Save $56 billion!


A retired person is already covered by Medicare
Underemployed will pay 4.75% health tax on any income.
A single person or a family with annual wages of $100,000 will pay $395./mo. (4.75%)
All medical,dental, optical,mental, care and prescription drugs Plus long-term care for ALL.
Employers will pay a 4.75% healthcare tax on all employees.
Family of four with annual wages of $40,000 will pay $150 per month. (4.75%)
Self-employed person will pay 4.75% of their annual income.

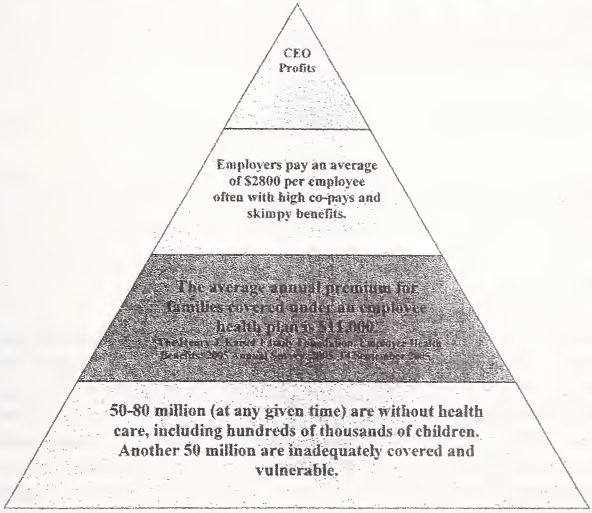
These examples show what we will pay for the USNHI Act: No healthcare bills, no co-pays, no-deductibles, no hidden costs. Just carry your card and get Health Care.

H.R. 676, the United States National Health Insurance Act: Maintain current federal and state funding for existing health programs; establish an employer and employee healthcare payroll tax of 4.75% each (this includes the 1.45% payroll money already being paid for Medicare); establish a 5% health tax on the wealthiest 5% of income earners; establish a 10% health tax on the wealthiest 1% of income earners; levy a 1/4 of 1% tax on stock transfers; repeal the Bush tax cut for the wealthiest income earners.

The Current Healthcare Crisis in the U.S

For-Profit Insurance Companies get Wealthier, Insurance and Pharmaceutical CEO's Make Hundreds of Millions, Americans Are DYING for Health Care.

$1.918 trillion


CEO Profits
Employers pay an average of $2800 per employee often with high co-pays and skimpy benefits.
The average annual premium for families covered under an employee health plan is $11,000.
50-80 million (at any given time) are without health care, including hundreds of thousands of children. Another 50 million are inadequately covered and vulnerable.

This comparison shows a savings of $56 billion annually for the United States while everyone is covered for health care.

Healthcare-NOW, the movement in support of a national single payer healthcare system
1-800-453-1305 www.healthcarenow.org.

This is a Summary of the study conducted by The Lewin Group, the full report is available at www.dist23.casen.govoffice.com under Studies & Reports. I feel that this study clearly points out the savings which result from a Single Payer system which would provide health care for everyone in the fairest way possible. Most plans call for a "shared responsibility" - this system does just that with government, employers and individuals all supporting the program but doing so in an affordable way with progressive taxes rather than regressive taxes which is part of the current system. It also ensures that individuals have no extra out-of-pocket expenses and can be assured of coverage with portability and no denials of coverage.

The Health Care For All
Californians Act:
Cost and Economic Impacts
Analysis
Executive Summary
Analysis Based Upon SB 921 as of April 30, 2004
With Clarifications Provided by Author's Staff
Prepared for:
Health Care for All Education Fund
by:
John F. Sheils
Randall A. Haught
January 19, 2005

The Health Care For All Californians Act (SB 840) (formerly SB 921)

The Act would cover all Californians under a single health plan that is administered and funded by the state. The program would replace all current public-sector insurance systems for Californians including: Medicare, Medi-Cal, Healthy Families, and military dependent coverage. It would also replace private health insurance plans in the state (with the exception of insurance purchased to cover services not covered by the Act. However, the medical component of the workers compensation system would be unchanged and would continue to operate separately for work related illnesses. The program would be financed with current government health care funding for discontinued programs, a payroll tax to replace employer benefits plans and other taxes to replace the premiums currently used to finance health care in the state.
The program's benefits package covers a broader range of services than are now covered under many health plans. The program would cover medically appropriate hospital inpatient and outpatient care, emergency room visits, physician services (including preventive care), prescription drugs, lab tests, mental health and substance abuse treatment, eyeglasses and other services. The program would also cover home health and adult daycare services for the aged and/or disabled. Dental care would be covered along with vision exams and hearing. It would not cover cosmetic surgery, some orthodontia and private hospital rooms (unless medically necessary).

We estimate that total health spending for California residents under the current system will be about $184.2 billion in 2006. This includes spending for benefits and administration currently covered by all payers including governments, employers and families. We estimate that the Act would achieve universal coverage while actually reducing total health spending for California by about $8.0 billion

The cost of these increases in utilization would be more than offset by savings from administration simplification and bulk purchasing savings. The Act would replace the current system of multiple public and private insurers with a single source of payment for all covered services, resulting in savings of about $19.9 billion in insurer and provider administrative costs. Savings from bulk purchasing of prescription drugs and durable medical equipment (e.g., wheelchairs) would be about $5.2 billion.

We estimate an increase in health services utilization of about $17.1 billion as comprehensive health insurance coverage is extended to all Californians. This would be more than offset by savings of $25.0 billion due to administrative simplification and bulk purchasing of prescription drugs and medical equipment.

State and Local Government Spending

Program expenditures under the Act would be about $166.8 billion if fully implemented in 2006. This includes about $150.2 billion in payments to providers for primary and acute care services and about $13.7 billion in spending for long-term care services (Figure ES-2). The cost of administration under the program would be about $2.9 billion, which is equal to about 1.8 percent of total program costs.
Funding sources for the Act would include funding for existing government health benefits programs and new dedicated taxes under the program to replace the premiums used to finance health care in the current system. Total government spending for discontinued programs would be about $72.1 billion in 2006, of which about $54.9 billion is federal funding for Medicare, Medi-Cal and other federal health benefits programs. This assumes that federal law is changed to transfer federal funds for California residents under these programs to the Act, which would then be responsible for covering these beneficiaries. It also includes about $17.2 billion in state and local government funding for Medi-Cal, Health Families and other safety-net programs.

The balance of program funding ($94.6 billion) would be revenues from newly created taxes that replace existing premium payments for employer-sponsored insurance (ESI), and individual payments for health insurance premiums. These taxes include:
An employer payroll tax equal to 8.17 percent of wages and salaries for all employees ($55.7 billion);
An employee payroll tax equal to 3.78 percent of wages and salaries for all workers ($25.8 billion);
A tax on net business income for the self-employed of 11.95 percent ($8.3 billion);
Tax on unearned income of 3.5 percent ($3.5 billion); and
Surcharge on income over $200,000 of 1.0 percent ($1.3 billion).

There is a floor on taxable income of $7,000 and a ceiling on taxable income of $200,000 for each of these taxes, except the surcharge on income over $200,000.
In addition, state and local governments would save about $900 million in spending for health benefits provided to state and local government workers and retirees. This is because the payroll tax payment for these workers under the Act would be less than what state and local governments are now paying for worker and retiree health benefits. As a consequence, the net cost of the program to state and local governments is a savings of about $900 million in 2006.

Impact on Private Employers

We estimate that under current law, private employers in California will spend about $49.6 billion on health benefits for employees, dependents and retirees in 2006 (includes employer costs less employee contributions; excludes workers compensation). This includes about $46.8 billion in spending for workers and dependents and $2.8 billion in spending for retirees. Under the Act, this coverage would be eliminated and replaced with a payroll tax of 8.17 percent on earnings between $7,000 and $200,000 for each worker.
Employers who currently offer health benefits would find that their payroll tax payment ($41.7 billion) is on average about 16 percent less than what they will pay for health benefits under current law in 2006 (i.e., savings of about $7.9 billion). This is even after accounting for payroll tax payments for employees that are not now covered under the employer's plan. Firms that do not now offer insurance would pay about $9.4 billion in payroll taxes in 2006.
Private employers that now offer insurance will spend about $4,723 per worker in 2006 under current law (Figure ES-3), reflecting the high cost of insurance for small groups in the current system. Average spending per worker for currently insuring firms would actually decline by about $775 under the Act to about $3,947 per worker. Firms that do not now offer coverage would also pay the payroll tax. The average cost per worker in these firms would be about $2,290. Savings would be greatest for insuring firms that provide the most comprehensive coverage. For example, currently insuring firms that cover 80 percent or more of their employees would on average see savings of about $2,186 per worker (Figure ES-4). On average firms that cover 80 percent or more of their workers would see savings across all firm size groups.

Household Impacts

Under current law, Californians will have out-of-pocket spending for health services and health insurance premiums averaging about $2,788 per family in 2006 (Figure ES-5). This includes family premium payments and employee contributions for ESI averaging $1,558 per family, and direct payments for health services including insurance co-payments of $1,229 per family.
We estimate that average family spending for health care would decline to about $2,448 per family under the Act in 2006, which is an average savings of about $340 per family. This reflects the elimination of nearly all premiums and co-payments for health services, offset by the new household tax payments created to replace premium payments under the current system. It also reflects changes in wages as employers adjust to changes in spending for health care. Thus, households on average see a net reduction in health spending, even after we account for the new taxes that households would pay to replace current premium financed health insurance system.

Spending in Future Years

The program would have long-term impacts on health spending in California. The growth in total program expenses under the Act would be constrained not to exceed the long-run rate of growth in state gross domestic product (GDP), which is projected to be about 5.14 percent per year between 2006 and 2015. Total statewide health spending would increase from about $184.2 billion in 2006 to $345.6 billion by 2015 under current trends (Figure ES-7).
These state-wide health spending estimates include the cost of all health spending including both services covered under the Act and services not covered under the Act such as some nursing home spending.

: Family Income
By 2015, health spending in California under the Act would be about $68.9 billion less than currently projected (i.e., $345.6 billion). Total savings over the 2006 through 2015 period would be $343.6 billion. Savings to state and local governments over this ten-year
period would be about $43.8 billion. This reflects savings in health benefits for state and local government workers and the reduced rate of growth in state and local government contributions to the Act resulting from spending controls over time.

UHCAN™

To: United States Senate Committee on Finance Date: March 26, 2007
From: Universal Health Care Action Network (UHCAN) - Rachel Rosen DeGolia, Director
Re: March 14, 2007 Committee Hearing – "Charting a Course for Health Care Reform: Moving Toward Universal Coverage"

We applaud the Senate Finance Committee for convening this hearing to address our nation's most critical domestic issue: ***our failing health care system.*** For the past dozen years, comprehensive reform to achieve affordable, quality heath care for everyone in America has been dismissed as an impossible dream. During this time, health care costs have grown twice as fast as the overall economy and more and more Americans are uninsured or underinsured. The involvement of the federal government, which finances about 1/3 of the $2 trillion spent in the U.S. on health care, is vital if we are to successfully address our nation's health care crisis.

The Citizens' Health Care Working Group was designed to bring the voices of the people to the federal government. After 18 months of a remarkable process - including six regional hearings, 84 community meetings, more than 20,000 individual responses to their survey, and 7300 responses to its Interim Recommendations - the Citizens' Health Care Working Group released its Final Report at the end of September. After a four month delay, the president has now issued his comments. Unfortunately, the Administration's comments largely restate old policies and reflect little recognition of the views held by a great majority of Americans as revealed in numerous national polls, or of *the peoples'* answers as voiced to the Working Group.

The Working Group's Final Recommendations convey a strong set of values and principles. Its overriding message is inclusiveness: all must receive ***"benefits that are sufficiently comprehensive to ensure access to appropriate, high-quality care without endangering individual or family financial security."*** The Working Group deserves our congratulations for its diligent pursuit of its charge to "engage Americans in an informed national public debate," and for issuing this strong call to action to our government.

We believe the first recommendation, to "**Establish Public Policy that All Americans have Affordable Health Care**," and, to take "immediate action with a target of 2012 for ensuring a core set of benefits and services for all Americans," to be the Working Group's most important recommendation. This recommendation reflects the Working Group's adherence to its mandate to develop recommendations based on what they heard from the public, not their personal or organizational beliefs.

The voices the Working Group heard from across the country were largely united: the 1st choice at over 2/3 of the Community Meetings, and the choice that over 70% of on-line survey participants' support was to ***"Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance."*** *(see attached Charts 1-4)* [Working Group Interim Rec. Appendix B:7; Appendix C:6, 12g]

The paths to affordable, quality health care for all will ultimately require substantive legislation to be enacted at the federal and state levels. A valuable first step, as indicated in this first recommendation, would be to *promptly* make it public policy for all Americans to have affordable health care. **We strongly believe that this goal of comprehensive, affordable health care for all must be achieved no later than 2012.**

As you move forward with your series of hearings "Moving Toward Universal Coverage," we strongly encourage the Committee to utilize the Institute of Medicine of the National Academy of Sciences set of principles to guide the debate and evaluate proposed strategies on which America could move toward affordable health care for all:

1. Health care coverage should be universal.
2. Health care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable to society.
5. Health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable. [www.iom.edu/?id=17632&redirect=0]

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Recommendation 2: Guarantee Financial Protection Against Very High Health Care Costs
While it is worthwhile to eliminate the uniquely American phenomenon of medical bankruptcy, this is only part of the affordability problem in health care. ***The goal needs to be to remove financial barriers to health care.*** Shared responsibility for financing care cannot mean high patient cost-sharing. Making premiums affordable by requiring high deductibles or high co-pays at point-of-service would create shallow insurance that Americans could not afford to use.

The recommendation for a national program is also hampered by the statement that it should be public or private. It might combine both public and private elements. Medicare has won widespread support by combining private delivery of care with public coverage.

Rather than leaning on a market approach and requirements for Americans to "shop around for the best deal for their health care needs" to contain costs, we strongly encourage the Committee to utilize public policy tools such as:

- slashing administrative costs by eliminating the complexity of thousands of different insurers and plans,
- capping the share of health insurance premiums that can be used for administration, marketing and profit,
- federal government negotiations to cut drug prices for Medicare and all Americans, which over 70% of on-line survey participants support. [WG Int. Rec. Appendix C:4, 8e]

Coupling cost controls with coverage expansion would make broad and deep coverage affordable now.

Recommendation 3: Foster Integrated Community Health Networks
While we believe in expanding integrated community networks, we strongly feel that this should not entail modifying the Federally Qualified Health Center concept.

Providing high quality coordinated care to vulnerable populations through integrated community networks is a worthwhile goal. But coordination has to be between ambulatory care and in-hospital care, between primary care and specialty care. The problems faced by providers in the current safety net stem from both under funding and obstacles to obtaining hospital and specialist care. Indeed, a true integration would mean the gradual disappearance of a separate sector called "the safety net" as a comprehensive system is implemented.

Recommendation 4: Define Core Benefits and Services for All Americans
The statement that "benefits that are sufficiently comprehensive to provide access to appropriate, high-quality care without endangering individual or family financial security" reflects belief that ***benefits that are broad in scope are indeed vital.***

Americans, as reflected in the survey responses, clearly want broad, inclusive, comprehensive benefits; and reject exclusion of types of care as a main tool to limit cost. Additionally, Americans want transparency, public participation and accountability in the process in establishing core benefits to be covered. *(see attached Chart 5)*
[Interim Recommendations, Appendix C, Online Poll, Q.4.; CHCWG: Executive Summary, pg iv.]

Clearly some types of services are not medically necessary and should not have their costs shared. For example, no one would argue that the costs of liposuction are a social responsibility. However, the delivery of non-core benefits is not what makes American health care so unaffordable.

The cost problem in American health care results from 3 main sources:

- prices for care in the U.S. are too high,
- administrative costs of highly fragmented private insurance,
- too many core services are performed in clinical situations where they are of little to no benefit.

Shared social responsibility for covering the cost of health care also entails social responsibility for containing costs, including prices. Cutting prices cannot be left to individual patients' comparison shopping.

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Recommendation 5: Promote Efforts to Improve Quality of Care and Efficiency
The five specific areas in which the promotion of better quality and greater efficiency are proposed are all reasonable and important. As stand-alone goals, their utility is limited.

To the extent that health care remains fragmented and discontinuous, they cannot achieve their potential. The promotion efforts in these areas need to be designed to accelerate the integration and coordination of care, to promote continuity of care, and to allow for choice.

Recommendation 6: Fundamentally Restructure the Way End-of-Life Services are Financed and Provided
These are laudable goals. While the provision of palliative care is a specially challenging phase in families' lives, the principles and concepts from this sector of health care need to be applied to everyone with chronic diseases.

We thank you for carrying forward the voices of the American people and the call of the Citizens' Health Care Working Group for ***public policy*** to achieve affordable, quality health care for all. **We expect these hearings to generate *concrete action* that moves our nation toward this goal.**

We would be happy to provide any additional information needed to clarify our positions, as well as a list of experts willing to make themselves available to testify before your Committee. Thank you for your time and attention to this critical issue.

Sincerely,

Rachel Rosen DeGolia

Rachel Rosen DeGolia, Director
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Enclosures (5)

Citizens' Health Care Working Group: Summary of Community Meeting Data – Chart 1

RANKINGS OF PARTICIPANTS AT EACH MEETING WHERE QUESTION WAS ASKED THIS WAY:

Please rate each of the following public spending priorities to reach the goal of health care that works for all Americans.

Meeting Site	Guarantee Enough Providers	Invest In Public Health	**Guarantee Health Insurance for All**	Develop Health Information Technology	Improve Minority Access	Biomedical and Technological Research	Ensure Health Care for All, including Safety Net Programs for Poor	Preserve Medicare and Medicaid
Billings, MT	4th	1st	5th	3rd	8th	6th	2nd	7th
Charlotte, NC	5th	1st	4th	8th	7th	6th	2nd	3rd
Cincinnati, OH	4th	2nd	1st	8th	7th	6th	3rd	5th
Denver, CO	6th	4th	1st	8th	5th	7th	2nd	3rd
Des Moines, IA	3rd	2nd	1st	6th	5th	4th	7th	8th
Detroit, MI	3rd	2nd	1st	7th	4th	6th	8th	5th
Eugene, OR	5th	2nd	1st	7th	4th	8th	3rd	6th
Indianapolis, IN	3rd	2nd	1st	8th	5th	7th	4th	6th
Jackson, MS	3rd	5th	2nd	8th	4th	7th	1st	6th
Miami, FL	7th	4th	1st	8th	6th	5th	2nd	3rd
Phoenix, AZ	4th	2nd	1st	6th	3rd	5th	8th	7th
Providence, RI	5th	3rd	1st	7th	2nd	8th	4th	6th
Salt Lake City, UT	4th	1st	5th	6th-T	8th	6th-T	3rd	2nd
Seattle, WA	2nd	3rd	1st	8th	4th	7th	6th	5th

*"Citizens' Health Care Working Group, Dialogue with the American People
Appendix B: Summary of Community Meeting Data
www.citizenshealthcare.gov/recommendations/appendix_b.php

Reprinted with highlights by the **Universal Health Care Action Network**, www.uhcan.org

Citizens' Health Care Working Group: Summary of Community Meeting Data – Chart 2

RANKINGS OF PARTICIPANTS AT EACH MEETING WHERE QUESTION WAS ASKED THIS WAY:

If you believe it is important to ensure access to affordable, high quality health care coverage and services for all Americans, which of these proposals would you suggest for doing this?

Meeting Site	Individual Tax Incentives	Expand State Medicaid, SCHIP, etc.	Rely on Free Market	Expand Medicare/ FEHBP	Expand Employer Tax Incentives	Employer Insurance Mandate	Expand Neighborhood Health clinics	**Create a National Health Program**	Individual Insurance Mandate	Increase State Program Flexibility
Billings, MT	8th	6th	10th	3rd	7th	9th	2nd	1st	4th	5th
Charlotte, NC	6th	10th	9th	3rd	4th	8th	2nd	5th	1st	7th
Denver, CO	9th	6th	10th	3rd	8th	7th	2nd	1st	4th	5th
Des Moines, IA	7th	6th	10th	2nd	8th	9th	3rd	1st	4th	5th
Detroit, MI	9th	6th	10th	3rd	8th	4th	2nd	1st	5th	7th
Eugene, OR	9th	6th	10th	5th	8th	7th	2nd	1st	4th	3rd
Indianapolis, IN	5th	6th	10th	4th	9th	8th	3rd	1st	2nd	7th
Jackson, MS	9th	7th	10th	3rd	4th	6th	2nd	1st	5th	8th
Kansas City, MO	7th	4th	NA	3rd	5th	9th	2nd	1st	6th	8th
Memphis, TN	7th	5th	10th	3rd	9th	6th	2nd	1st	4th	8th
Miami, FL	9th	4th	10th	3rd	6th	7th	2nd	1st	5th	8th
New York, NY	9th	4th	10th	2nd	8th	6th	3rd	1st	5th	7th
Philadelphia, PA	9th	7th	10th	3rd	8th	5th	2nd	1st	4th	6th
Phoenix, AZ	7th	9th	10th	5th	6th	4th	2nd	1st	3rd	8th
Providence, RI	9th	8th	10th	4th	7th	6th	2nd	1st	3rd	5th
Sacramento, CA	8th	7th	10th	3rd	9th	6th	2nd	1st	4th	5th
Salt Lake City, UT	6th	7th	9th	5th	8th	10th	2nd	3rd	1st	4th
Seattle, WA	9th	7th	10th	4th	8th	6th	2nd	1st	3rd	5th
Tucson, AZ	7th	5th	10th	4th	8th	9th	3rd	2nd	1st	6th

Note: Participants in the Orlando and Baton Rouge community meetings did not answer a comparable question.

**Citizens' Health Care Working Group, Dialogue with the American People*
Appendix B: Summary of Community Meeting Data
www.citizenshealthcare.gov/recommendations/appendix_b.php

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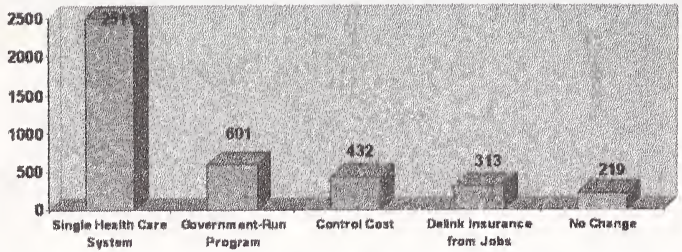
Citizens' Health Care Working Group - Comments Received on Open-Ended Questions* - Chart 3

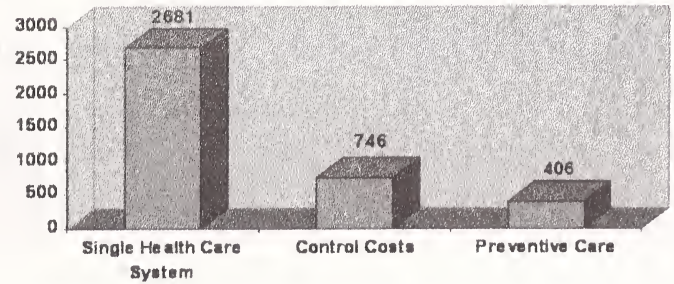
Figure 10: Our current way of paying for health care includes payments by individuals, employers, and government. Are there any changes you think should be made to this system?



As illustrated in Figure 10, analysis of the comments shows that when asked about what kinds of changes should be made to the way we currently pay for care, most wrote about the need for a single health care system. We know from the comments submitted as well as the discussions at the meetings that the notion of a single health care system means a number of different things to different people. For some, the most important issue clearly was the need for a government-run program. For others, it was an administratively simple program that would be available to everyone but provided in the public and private arenas. Among the 2,511 respondents who wrote about the need for a single health care system in response to an open-ended question about how health care should be financed, 43 percent recommended a single-payer system, while 24 percent discussed national health care and 18 percent discussed universal health care. The remainder discussed the ideas of universal Medicare, universal coverage, universal basic care, or universal access

And, while a minority expressed the view that market reforms and advancements in technology could help to control costs and lead to better access to care, most of the people we heard from want more fundamental change. The same notion—the need for a single national health care system—dominated the responses to the final question that asked people for the single most important recommendation for improving health care for all Americans. See Figure 11.

Figure 11: What is your single most important recommendation to make to improve health care for all Americans?



There is a great deal of diversity in the ways people envision a reformed system. They believe this can be accomplished, and most believe that the resources are already there in our current system to achieve this goal.

*excerpt from Citizens Health Care Working Group Dialogue with the American People
www.citizenshealthcare.gov/recommendations/dialogue.php#sumfind

Prepared by the
Universal Health Care Action Network.
www.uhcan.org

Citizens' Health Care Working Group: Summary of Community Meeting Data – Chart 4

Dialogue with the American People, Appendix B: Summary of Community Meeting Data

	% of Community Meeting Attendees Who Think Affordable Health Care Should be Public Policy:
Albuquerque, NM	90.40%
Baton Rouge, LA	85.50%
Billings, MT	90.20%
Charlotte, NC	92.00%
Cincinnati, OH	98.20%
Denver, CO	92.90%
Des Moines, IA	92.50%
Detroit, MI	98.70%
Eugene, OR	91.20%
Fargo, ND	89.40%
Hartford, CT	100.00%
Indianapolis, IN	94.90%
Jackson, MS	91.40%
Kansas City, MO	90.70%
Las Vegas, NV	87.40%
Lexington, KY	93.60%
Little Rock, AR	96.80%
Los Angeles, CA	95.40%
Memphis, TN	95.90%
Miami, FL	91.70%
New York, NY	97.10%
Orlando, FL	90.40%
Philadelphia, PA	99.30%
Phoenix, AZ	91.50%
Providence, RI	93.50%
Sacramento, CA	97.60%
Salt Lake City, UT	77.20%
San Antonio, TX	95.50%
Seattle, WA	97.10%
Sioux Falls, SD	97.00%
Tucson, AZ	93.20%
Weighted average	94.10%

	% of Community Meeting Attendees Who Believe that Health Care Should Cover a Level of Benefits for All:
Albuquerque, NM	89.00%
Baton Rouge, LA	67.9%
Billings, MT	87.00%
Charlotte, NC	81.10%
Cincinnati, OH	90.30%
Denver, CO	95.00%
Des Moines, IA	92.60%
Detroit, MI	95.20%
Eugene, OR	95.60%
Fargo, ND	76.70%
Hartford, CT	96.80%
Indianapolis, IN	92.50%
Jackson, MS	91.70%
Kansas City, MO	80.6%
Las Vegas, NV	77.50%
Lexington, KY	92.80%
Little Rock, AR	95.80%
Los Angeles, CA	90.10%
Memphis, TN	90.40%
Miami, FL	78.9%
New York, NY	97.90%
Orlando, FL	81.1%
Philadelphia, PA	98.00%
Phoenix, AZ	97.20%
Providence, RI	82.60%
Sacramento, CA	91.00%
Salt Lake City, UT	81.30%
San Antonio, TX	92.90%
Seattle, WA	93.20%
Sioux Falls, SD	77.40%
Tucson, AZ	93.20%
Weighted average	89.90%

Source: Citizens' Health Care Working Group, Dialogue with the American People, Appendix B: Summary of Community Meeting Data
www.citizenshealthcare.gov/recommendations/appendix_b.php

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Citizens' Health Care Working Group: Summary of Community Meeting Data – Chart 5

On a scale of 1 (no input) to 10 (exclusive input), how much input should each of the following have in deciding what is in a basic benefit package?

Meeting Site	Consumers	Medical Professionals	Federal Government	State/Local Government	Employers	Insurance Companies
Billings, MT	6.3	6	5.1	4.7	4	2.4
Denver, CO	6.8	6.4	4.2	4	3.8	2.5
Des Moines, IA	6.7	5.4	5	4.7	2.6	2.2
Detroit, MI	7.6	6.8	3.5	3.7	2.4	1.4
Indianapolis, IN	7.6	6.1	4.9	3.9	3.3	2.2
Jackson, MS	7.8	5.7	3.6	3	3.6	1.8
Miami, FL	6.9	5.5	5	4.5	3	2.3
New York, NY	7.7	6.7	5.2	4.1	2.1	1.4
Philadelphia, PA	6.7	6	4.4	4.4	3.1	1.5
Phoenix, AZ	7.7	5.2	3.9	3.7	3.4	2
Providence, RI	8	6.8	4.1	3.8	2.8	2.3
Sacramento, CA	7.4	6.4	3.8	3.8	2.9	2.5
Salt Lake City, UT	6.8	4.9	4.6	4.7	3.1	2.6
Seattle, WA	7.3	5.9	4.3	4	2.3	1.6
Tucson, AZ	6.6	6.2	3.9	3.4	3.2	2.6
Meeting Average	**7.2**	**6**	**4.4**	**4**	**3**	**2.1**

Note: Not included are community meeting data from Kansas City, Albuquerque, Hartford, Las Vegas, Eugene, San Antonio, Fargo, Lexington, Little Rock, and Sioux Falls because participants did not answer a comparable question. In the Orlando community meeting, participants grouped responses into categories that were not comparable with the other meetings.

Who ought to decide what is in a basic benefits package? (SELECT ONE.)

Meeting Site	Consumers	Medical Professionals	Government	Employers	Insurance Companies	Combination
Baton Rouge, LA	19.00%	8.60%	5.20%	1.70%	0.00%	65.50%
Charlotte, NC	23.50%	3.70%	1.20%	1.20%	1.20%	69.10%
Cincinnati, OH	25.80%	7.90%	3.60%	1.00%	0.50%	61.20%
Los Angeles, CA	20.60%	15.40%	2.60%	0.40%	0.40%	60.70%
Memphis, TN	28.40%	6.20%	4.90%	0.00%	0.00%	60.50%
Weighted Average	**23.80%**	**9.70%**	**3.30%**	**0.80%**	**0.50%**	**62.00%**

Source: Citizens' Health Care Working Group, Dialogue with the American People
www.citizenshealthcare.gov/recommendations/appendix_b.php

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Senate Finance Committee

Charting a Course for Health Care Reform: Moving Toward Universal Coverage

March 14, 2007

Testimony of the Washington State Ad Hoc Coalition on the Citizens Health Care Working Group

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Senator Max Baucus, Chair, and Members of the Senate Finance Committee including our own Washington Senator Maria Cantwell:

Introduction

We are individuals and members of several different Washington State organizations that are committed to the creation of a high quality American health care system that is affordable and accessible to all. We came together over a year ago as an Ad Hoc Coalition in support of the Citizens Health Care Working Group (CHCWG) and its public hearing held in Seattle in February 2006. We submitted a critique and recommendations for improvement of the Interim Report last summer. We now testify before the Senate Finance Committee about the CHCWG report "Health Care That Works for All Americans", and make further comments about implementation of reform of the American health care system.

First of all, we second the comments made by Sen. Baucus in his opening remarks. We agree that health is the first of all liberties, and that it is a responsibility of society to provide health care for all its residents. We think it is helpful to view health care as part of the essential infrastructure of our nation. Further, the use of tax dollars to guarantee the health care of American citizens is an appropriate investment in America's future. We share Sen. Baucus' belief that a nation-wide consensus is forming around five principles for our health care system:

1. Universal coverage - indeed an essential first step enabling the others
2. Sharing the burden - depending on employers and individuals alone is not sufficient
3. Controlling costs - only a unified system can implement evidence-based methods to control costs fairly

4. Prevention - this is a major area in which the current American system fails, with its overuse of lucrative procedures and lack of emphasis on maintenance of health
5. Sharing responsibility - everyone contributes both to paying the cost of the system and to being responsible for personal lifestyle and health care decisions.

Findings of the CHCWG

1. Strong Support for National Health Care Coverage for All Americans

The most important finding is expressed in the statement:

"Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to ensure access to appropriate, high-quality care without endangering individual or family financial security."

There was overwhelming support (94%) that there should be public policy written into law that all Americans have affordable health care. Of participants at community meetings across the nation, 68 - 98% favored guaranteeing a defined set of health care benefits to everyone. In another national poll in September 2005, 75% of U.S. adults favored health insurance that covers all Americans.

2. Financing a National Health Coverage Is Affordable

At $2 trillion per year, about $6,000 per person, or 16% of Gross Domestic Product, there is plenty of money being spent on health care in America. There was also a strong sense in the public responses that reallocation of health care dollars would provide the necessary funds for universal coverage. Nevertheless, a majority of participants in the CHCWG process were willing to pay more in taxes to ensure that all Americans are covered.

There was also strong sentiment that financing methods should be "fair", meeting the following principles:

- No disproportionate financial burden on the sick
- Responsibility related to a household's ability to pay
- All segments of society should contribute to funding

3. The Time to Start the Transition to National Health Coverage is NOW

The overwhelming majority of participants want the health care system change to begin now. Full implementation of national health coverage should be accomplished at least by 2012.

4. Band-Aids: Suggestions to Provide Immediate Relief from the Worst Problems of a Grossly Inadequate System

The CHCWG report devotes several pages to schemes to stabilize the failing private health insurance system and to provide help for families bankrupted by catastrophic health care costs. A few more pages were spent on supporting community health clinics as safety net providers for the poor and uninsured.

5. Preparing the Health Care Delivery System for Universal Coverage

CHCWG recommendations 3-6 all relate to this basic issue. There are several ways in which the American health care system needs to be restructured to provide the best care possible for everyone once universal coverage is established. Some of these:

- Increase the number of primary care health professionals - studies of other nations show that ready access to primary care is an essential building block for a successful, cost-effective health care system.
- Develop community-based integrated delivery systems - not just for the poor and/or uninsured. Systems like these already are delivering top quality care in the communities where they exist.
- Implement electronic medical records nation-wide - develop intercommunication among various systems. Information technology on this scale cannot be financed or integrated on the backs of individual physicians and hospitals.
- Fund nation-wide research to document the evidence needed for recommended diagnostic and treatment approaches for common diseases.
- Develop population-based strategies for many health services, especially support for healthy lifestyles, preventive care, and management of common chronic diseases.
- Create a transparent and independent process for defining benefits to be included in universal coverage, and for updating benefits as technology and knowledge change.
- Create a multidisciplinary system to coordinate and deliver end-of-life care.

Washington State Ad Hoc Coalition Opinions

1. Fundamental Reform: Universal Health Coverage for All Americans

We cannot emphasize strongly enough how important it is for Congress to declare its intent to design and implement a universal health coverage system that guarantees affordable health care with dignity to every American. Without this essential first step, other reforms are too expensive, unfair, or simply won't work. The time to do this is NOW.

A multitude of national polls demonstrate that the public is strongly in favor of guaranteed health coverage, that government should make it happen, and that it should be tax-supported.

2. A Single National Health Coverage Program Will Save Enormous Sums

The CHCWG report did not dwell on the tremendous waste inherent in the current fragmented system, but a large amount of the annual $2 trillion paid for American health care is waste:

- The administrative bureaucracy of hundreds of private and public insurers plus the costs to health providers of their own bureaucracies needed to navigate the billing and collection process of the fragmented payment system costs at least 1/3 of total health care expenditures. (That's $600 billion per year!) The administrative cost of a single national coverage plan would be less than 10% of total costs, a conservative estimate, - a savings of at least $400 billion per year.
- Without any way to control costs, the U.S. has overbuilt high technology diagnostic and treatment options, and developed too many expensive specialists, while underpaying primary care health professionals.
- Without any organized way to educate and support health professionals, nationally agreed upon evidence-based guidelines for appropriate diagnostic and treatment choices are rarely used, resulting in overuse of some, underuse of others. Unnecessary waste and avoidable suffering result from wrong decisions.
- Lack of health insurance drives millions to seek health care from the most expensive place possible - emergency rooms - when they are sick and/or scared.
- Demand driven by advertising to the general public leads to overuse of medications and devices, with resulting waste of dollars as well as unnecessary suffering from side effects of medications that were not needed in the first place.

The report does state: "...a significant portion of all health care expenditures produce no added health value." And: "Concentrated efforts in some integrated health care systems have demonstrated care can be improved and waste eliminated."

3. We Urge Congress to Start the Work of Preparing the Health Care Delivery System for Universal Coverage.

Lulled by the common myth that Americans have "the best health care in the world", little attention has been given to the delivery system improvements that must be made for our health care system to work as an efficient integrated system once everyone has coverage.

The seven bullets under heading #5 above list a minimum of what is needed. Congress needs to convene another working group to review these areas, think of more problem areas, and develop solutions with funding for implementation. None of these is difficult, and we can use work already done in other nations to find the necessary solutions.

Improving American health care delivery will cost money, but investment in an improved delivery system, in combination with universal coverage, should result in substantial sustained monetary savings and improved health outcomes in the future.

4. Designing a Sufficiently Comprehensive Benefit Package

We believe it is crucial that a national health coverage plan be sufficiently comprehensive to provide good protection for all Americans from excessive out-of-pocket costs. Terms like "basic" and "core" imply skimpiness (who would want just the core of an apple, for example). Americans are not going to be willing to give up what they have now, as imperfect as it is, if they think the new system is going to have skimpy benefits. Public opinion, as tabulated by the CHCWG, is very clear: Americans want to be able to get the health care they need, when they need it, and without risking financial ruin.

The independent committee charged with the transparent, publicly accountable process for determining the benefits package must use evidence-based science demonstrating medical effectiveness as well as cost effectiveness. The process must also assure over time that the benefits package remains current and continues to be both medically effective and cost effective. The benefits must cover wellness care, preventive services, primary care, acute care, prescription drugs and devices, patient education, treatment and management of health problems - physical, mental and dental - with care decisions made by patients and their doctors together. The members of the committee and their families will get the same excellent quality care expected for all Americans.

Conclusion

We wish to re-emphasize the overwhelming support evident in all the public input to the CHCWG for a national health program, financed by taxes, covering all Americans for a sufficiently comprehensive package of health services.

- **97%** view the health system as in crisis or having major difficulties
- **94%** believe affordable health care should be a matter of public policy, by law
- **90%** think health care should cover a level of benefits for everyone.

We think numbers like these represent a consensus. Does Congress have the political will to enact a national health program supported by a consensus of public opinion? We look forward to your leadership and trust that you will make comprehensive health care reform and a commitment to a healthy future for all Americans top priorities in 2007.

Supporting Organizations

(in alphabetical order)
Alliance for Retired Americans - Puget Sound
Alliance for Retired Americans - Washington
Health Care for All - Washington
Health Care That Works (6th Congressional District)
Lutheran Public Policy Office of Washington
Northwest Federation of Community Organizations
Northwest Health Law Advocates
Physicians for a National Health Program - Western Washington
United for National Health Care (2nd Congressional District)
Service Employees International Union 1199NW
Washington Community Action Network

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